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Focus on the Community:

Interview:

- *Carolyne Davis, Chair, CHAP Board of Governors*

Resource Utilization in Home Care

Inadequate Reimbursement for Long[illegible]are

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Nurse Turnover in Skilled Long-term Care

Public and Community Health Nursing

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Resource Utilization in

Methods and Issues

June L. Helberg

Rapidly increasing health care expenditures over the last decade have resulted in programmatic efforts by federal and state governments to reduce the costs of providing health care to all segments of the population, particularly the elderly and chronically ill. Despite a shift from inpatient to outpatient care characterized by fewer hospital admissions and discharges, more outpatient visits, and increased use of home health agency services by Medicare beneficiaries, the prices charged consumers for medical care continue to outclimb nonmedical prices, as measured by the Consumer Price Index (Donham & Maple, 1989; Gornick & Hall, 1988; National Center for Health Statistics, 1988). Health policy efforts to contain costs have focused on increasing efficiency and decreasing the overall volume of services consumed. Thus, health care providers, irrespective of service delivery setting, are being forced to examine utilization patterns, to substantiate that care is provided in the least costly setting, to reduce the total amount of services provided, and to deliver only necessary care. Although Medicare benefit payments for home health agency services currently represent only a small percentage of total Medicare benefit payments, Medicare home health agency payments increased 148% between 1981 and 1986. Responding to this increase, the Health Care Financing Administration covered fewer visits per enrollee in 1985 than in 1984 and is considering a prospective payment system (PPS) for home care reimbursement (Gornick & Hall, 1988; Hoyer, 1988a,b). While a PPS has been implemented in the acute care setting, and costs are determined by diagnosis related groups (DRGs), payments to home care agencies are currently reimbursed retrospectively based on the number of home visits made. Prospective payment has been proposed for home care services to break the direct link between costs and revenues (Buck & Harris, 1987). Before a PPS can be implemented in home care, information is necessary in a multitude of areas, including alternative measures of resource utilization, methods and procedures

June L. Helberg, EdD, RN, is an assistant professor of nursing, University of Rochester, Rochester, New York. Research for this manuscript was supported in part by a FIRST Award (1 R29 NRO2000-02) from the National Center for Nursing Research, Public Health Service, U. S. Department of Health and Human Services.

Home Care

Helberg describes a model to determine patterns of home care resource use, analyzes data from ongoing research in terms of the model, and discusses implications of the study for future home care reimbursement.

Key Words: home care, resource utilization, reimbursement

to calculate these measures, and patterns of resource utilization. Such information could be valuable to home health agency administrators, third-party payors, and individuals responsible for the development of health policy as they consider alternative methods on which to base home care costs and charges.

Resource utilization definitions

Resource utilization refers to the amount of goods or services consumed, and should not be equated with either costs or charges. Cost is the transformation of resources used to a medium of exchange such as dollars, while charges are the monetary amount that goods and services are offered for in the marketplace (Kovner, 1989). The total amount of goods and services used must be known before the cost of an activity can be determined. The traditional measure of resource consumption or productivity in home care has been the home visit (Harris & Mattner, 1988; Schneider, 1989). However, time can also be used to measure resource utilization. Since time can be expressed using various numerical units, resource utilization can also be measured in minutes or days.

The amount of nursing resources consumed by home care patients, that is, number of visits, duration of care, time spent on nursing visits, and number of days between visits, should, in principle at least, be determined by a variety of factors. Any nursing model used to eventually predict home care nursing resource utilization must take into consideration patients' nursing problems, activities completed by the nurse on behalf of the patient, functional status, living arrangements, the availability of support from family and friends, and coping ability.

Measurement of resource utilization variables

The number of nursing visits is computed by summing the total number of effective home visits made to a client during an agency admission. The length of time a patient is open for service may be an alternative definition of resource consumption. It can be calculated by totaling the number of days the patient is open for nursing service for a particular admission. Patients can be considered to be open to nursing service the day of the first home visit rather than the day of referral to the agency, since there may be a delay between the time of referral and agency admission. The day of discharge from the agency can be determined either from the date of the last home visit to the patient, or from the date the patient is officially closed to the agency computer. Calculating the date of discharge as the date of the last home visit rather than closing on the computer may overlook other significant interventions such as phone contact made to the patient, conferences regarding the patient, or contacts to primary health care providers following the last effective home visit. Calculating the date of discharge as the date of computer closing may also give the nurse the opportunity to determine that no additional problems have arisen since the time of the final visit. It should be recognized that using the computer closing date as the date of agency discharge may inflate the length of time the patient is considered open for nursing service, since patients may be officially closed some time after the last home visit has been made. However, in practice, many home health agencies may fail to officially close patients on the day of the last visit, to avoid time-consuming and complex readmission procedures should the patient need to be seen soon after the date of the last official visit.

A third measure that could reasonably be used to gauge resource utilization is the total time, summed across visits, spent by the nurse for a particular patient admission. Time needs to be carefully defined to include either direct care activities only, that is, time spent in the client's presence on her or his behalf, or patient assignable nursing time that includes direct care activities as well as indirect activities conducted outside the patient's home. Indirect care includes a variety of activities such as charting, correspondence, and phone contacts for a particular patient.

Again, there are advantages and disadvantages to using either only direct time or patient assignable nursing time as a measure of resource utilization. Most obviously, including only direct care as a measure of resource utilization overlooks the myriad of other activities that must be completed by nurses to effectively manage clinical care delivered to clients. Previous research has indicated that home care nurses from a variety of agencies spent only 30% of their time on the average in direct care activities. Thus, in contrast to direct care activities, indirect care activities comprised on average 70% of the nurse's working day (Schuster & Cloonan, 1989). Time spent by nurse providers in case management activities such as travel, conferences, charting telephone calls, and meetings must be documented lest federal and state governments, third-party payors, and employers neglect to consider these activities in calculating home care reimbursement rates (Schuster & Cloonan, 1989). On the other hand, the greater the number of activities the nurse must consider in calculating the time spent on behalf of a particular patient, the more like-

ly it is that certain activities will be overlooked, or that it will be difficult for the nurse to separate out how much time was unique to the patient in question versus other patients in the caseload.

Health policy efforts to contain costs have focused on increasing efficiency and decreasing the overall volume of services consumed.

Nonetheless, measurement of direct care activities only is likely to provide useful information in so far as the information is easy for nurses to report and that there still is a relative lack of information which identifies the amount of time spent by home care nurses in direct clinical care activities for various patient groups. Including time spent on visits and the number of nursing visits as measures of resource utilization allows one to calculate the average amount of time spent in the delivery of care to particular patients or patient groups.

There is a fourth measure that, although not a direct indicator of resource consumption, reflects the degree of service intensity expended by agencies in the delivery of clinical services to home care patients. The degree of service intensity provided to patients may be identified by calculating the average number of days between successive visits to a particular patient. This is determined by adding the number of days between successive visits for all visits made to client for a particular admission and dividing by the number of visit intervals identified. A lower than average number of days between visits might be of concern to home care agencies. To obtain an accurate estimate of days between successive visits, it is necessary to know the date of each visit as well as how many visits were made on a particular day, as some patients may be visited more than once a day. To calculate this statistic, it is helpful to have computerized information available that chronologically identifies the dates of service provision.

A model to determine patterns of home care resource use

Patterns of home care resource utilization should be related to a variety of factors, such as DRGs and nursing diagnoses, and examined prospectively in various types of home care agencies, since particular service agencies may provide service to patients with specific needs or demonstrate different patterns of resource use. Thus, data on resource use is necessary from official, voluntary, hospital-based, and proprietary agencies. For chronically ill patients who are high utilizers with respect to service duration, this process could be expected to take more than 1 year. Utilization norms should be determined by calculating both the median and mean value for each measure of home care resource utilization being considered for all patients served by the home care program. Calculation of both the median and the mean is necessary, since the median is an average position in a distribution of values, and is insensitive to extreme variations in scores, whereas the mean can be affected by outlier scores (Polit & Hungler, 1987). Such information is likely to identify the utilization profile of a typical patient served by the agency. These same utilization norms should then be determined for specific DRGs or primary nursing diagnoses to determine the agency norm for the particular DRG or nursing diagnosis. The pattern of resource use for outlier cases in specific DRGs could then be examined to determine the reasons for outlier status. When aggregated across agencies of various types using large data sets, utilization norms on individual DRGs could serve potentially as the basis for a prospective payment mechanism for home care services (Table 1).

Application of the model

Methods. Home care utilization patterns were examined using the methodology described earlier. As part of a larger prospective investigation designed to determine the extent to which nursing classification, activities of daily living, aid from family and friends, family coping, medical, agency, and sociodemographic variables are related to the utilization of home care nursing services, patterns of home care resource use were examined for 145 subjects. Subjects included in the study had a primary medical or surgical diagnosis, had been admitted to the home care agency for nursing service, and received at least two nursing visits. An official home health agency in New York State serving an urban, suburban, and rural population was the setting for the study. Agency patients meeting eligibility criteria were selected for the study using systematic random sampling.

Following nursing discharge from the agency, data on utilization variables was obtained from the agency's computer. Data was obtained on the dates of effective nursing services and the amount of time spent by the nurse in the home for each effective visit.

Results. Eighty-one DRGs representing 145 subjects were included in the analysis. Twelve DRGs had greater-than-average utilization for at least two utilization measures and for at least two subjects, while an additional 12 DRGs had greater-than-average utilization for one utilization measure and at least two subjects. The average patient in the sample received almost 11 nursing visits averaging about 33 minutes per visit over a period of about 8 weeks and was

Table 1
Steps in a Model to Determine Resource Utilization

1. Calculate utilization norms (mean, median, standard deviation) for home care populations across all DRGs
2. Compute utilization norms for individual DRGs
3. Identify outlier cases for each individual DRG so that these cases can be examined in detail
4. Continue to gather utilization norms for entire home care population as well as for individual DRGs
5. Norms determined for individual DRGs become the standard for that DRG

Table 2
Utilization of Resources (N = 145)

	Total Visits	Total Time	Total Days	Days Between Visits
Mean	10.6	348	55.5	7.8
Median	6	205	41	6.1

visited approximately every 8 days (Table 2).

Seven DRGs had greater-than-average utilization across all measures. Clearly, further attention should be directed to resource use for these DRGs, because regardless of the utilization measure selected, use was greater than average and represents a potential drain on the use of agency services. A greater-than-average number of visits and total time accompanied by less-than-average total days and days between visits may indicate intensive use of services over a short time span. On the other hand, greater-than-average number of visits, total time, total days, and days between visits suggests that more general nursing surveillance may be necessary over a long period of time for chronic conditions, such as chronic obstructive pulmonary disease. Finally, an average number of visits and total days of care with increased total time and less-than-average number of days between visits implies that more frequent and longer visits may be necessary for an average number of days. Fewer-than-average days between visits by themselves should be of less concern to agency administrators because this pattern may indicate an overall average consumption of resources by patients who are visited frequently and then discharged. Similarly, above-average days of care by themselves should not be of concern to agency administrators because although the patient may be technically open for service, visits or time are not being consumed in excessive fashion (Table 3).

Implications for reimbursement

The method of analysis suggested by this research can be used by home care agencies to identify patterns of resource use within the agency. For example, does the agency tend to carry patients who require frequent visits of long duration over a short period of time, or does the agency tend to carry patients with chronic illnesses that necessitate monitoring over a longer time frame? An analysis of this type can also be used to examine patterns of resource use within the context of an individual nurse's caseload. Does the pattern of resource use by an individual nurse suggest that her caseload consists primarily of clients in need of short-term, intensive services, or does it suggest that she is following patients whose predominant needs are for more general health assessments? Also, do particular nurses tend to keep patients open for longer or shorter time frames, or spend more or less time in the conduct of visits?

Because of the small number of patients for whom utilization measures were available in this study, it was not possible to determine utilization patterns for all DRGs. It is also unknown whether the utilization norms established within this agency for individual DRGs would be consistent over time or would change appreciably. In principle at least, if agencies are to determine home care utilization norms for each DRG, a minimum of 20–25 cases per DRG is necessary to determine a reasonably accurate trend. In smaller home care agencies, it may be impossible to gather this type of information on each DRG. This latter point raises a significant issue for health policy. If a PPS is to be implemented in home care avoiding a shotgun approach, utilization norms must be available that accurately reflect the patterns of care being delivered in a variety of home care agencies, both large and small, from different geographic locations. Such research will require a coordinated, national, multisite approach.

Other important questions for both reimbursement and health policy are raised by this research. If home care visits are to be reimbursed on the basis of time spent in the home, individual providers and the home care agencies that employ them have an incentive to maximize the amount of time spent on each visit. Maximizing the amount of time spent on each visit may decrease the number of visits that can be made

Table 3
DRGs Exceeding Agency Home Care Utilization Norms (N = 145)

DRG	Total Visits	Total Time	Total Days	Days Between Visits
285 (N = 2)	75.5*	2334*	132*	2.0*
280 (N = 2)	62 *	1305*	116*	1.5*
218 (N = 4)	25.5*	735*	93*	4.1*
148 (N = 5)	20 *	702*	70*	4.3*
317 (N = 2)	17 *	893*	67*	4.2*
294 (N = 5)	15.2*	445*	106*	6.1*
277 (N = 3)	14.3*	475*	33	2.2*
271 (N = 4)	14.3*	378*	60*	7.4*
88 (N = 5)	10.8*	369*	89*	8.4
250 (N = 3)	8.7	418*	42	5.3*
238 (N = 2)	9	393*	36	3.2*
121 (N = 4)	6.5	231	58*	7.2*

* Exceeds overall agency mean.

DRGs: 285 = amputations for endocrine, nutritional and metabolic disorders; 280 = trauma to the skin, subcutaneous tissue and breast; 218 = lower extremities and humerus procedures, excluding hip, foot, and femur; 148 = major small and large bowel procedures; 317 = renal failure with dialysis; 294 = diabetes; 277 = cellulitis; 271 = skin ulcers; 88 = chronic obstructive pulmonary disease; 250 = fractures, sprains, strains and dislocations of forearm, hand, foot; 238 = osteomyelitis; 121 = circulatory disorders with AMI and cardiovascular complications, discharged alive.

and the number of patients seen in a day. This option, without restrictions on the amount of time that may be spent by the nurse, allows the nurse to deliver "quality" care. However, under this method, third-party payors would have an incentive to keep hourly rates for reimbursement low. On the other hand if care is to be reimbursed by the visit, providers and agencies have an incentive to minimize the amount of time spent on each visit so that nurses can make more visits. The current payment by the visit methodology rewards agencies for spending the least amount of time possible in the delivery of care. Third-party payors might consider reimbursing for care on the basis of the number of visits made or use an hourly charge, when the care provided is acute in nature, self-limiting, or can be resolved with provision of nursing service. On the other hand, third-party payors might consider a per case reimbursement methodology when patients have numerous chronic conditions and/or long-term surveillance is necessary to monitor for changes in health status.

Recent efforts by third-party payors to control costs have compelled home care agencies to examine resource utilization patterns for nursing services.

It should also be recognized that care reimbursed on the basis of the number of visits provided does not take into account the time spent on visits. It assumes that visits are equal in duration and equal in quality. Reimbursement by the visit may not reflect quality dimensions of home care services provided, such as activities undertaken by the nurse, the sophistication of psychomotor or interactional skills employed by the nurse, or the unique nursing problems of the patient.

For professional nursing practice, these are indeed critical issues that underscore a sensitive problem in both acute care and home care settings. The approach of this research implies that reimbursement for home care services should be based on DRTs rather than on nursing diagnoses or nursing problems. Research resulting from both acute care and home care settings are currently conflicting, with some studies indicating that DRGs accurately take into account needs of patients for nursing care and, thus, that DRGs may be satisfactory proxy for nursing care (Jones, 1989; Thompson & Diers, 1988; Trofino, 1988). However, other studies suggest that factors such as living arrangements, functional status, severity of illness, coping ability, nursing problems, and nursing care requirements in particular influence the utilization of home care services (Ballard & McNamara, 1983; Halloran & Kiley, 1987; Horn, Horn et al., 1986; Mion et al., 1988; Pasquale, 1987; Peters, 1988; Sovie et al., 1985). Unfortunately, at the current time third-party payors do not believe that there is compelling evidence that supports the provision of home care nursing services on the basis of primary nursing diagnoses or nursing care provided. Thus, nursing is concomitantly struggling to develop a nursing model on which to base reimbursement, and to convince federal, state, and private payors to reimburse for nursing care on the basis of that model.

Summary

Recent efforts by third-party payors to control costs have compelled home care agencies to examine resource utilization patterns for nursing services. Thus, many agencies have needed to take a reactive stance with respect to examining utilization patterns for their agency. In order to assure that reimbursement is based on a model that is realistic and reflective of patients' needs and care provided, home care providers must now take a proactive approach and examine utilization patterns in the context of multiple organizational, patient, medical, and nursing factors.

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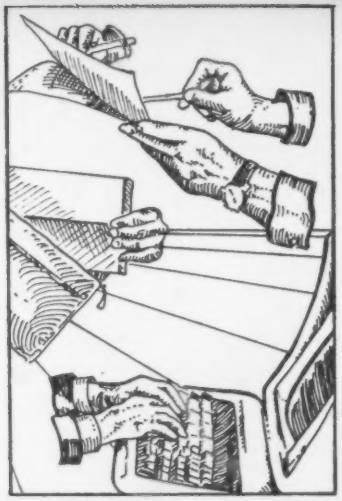

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The authors provide a background for this issue's articles, and they emphasize the need for development of nursing administration theory.

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Richard Foster and Heidi Boerstler

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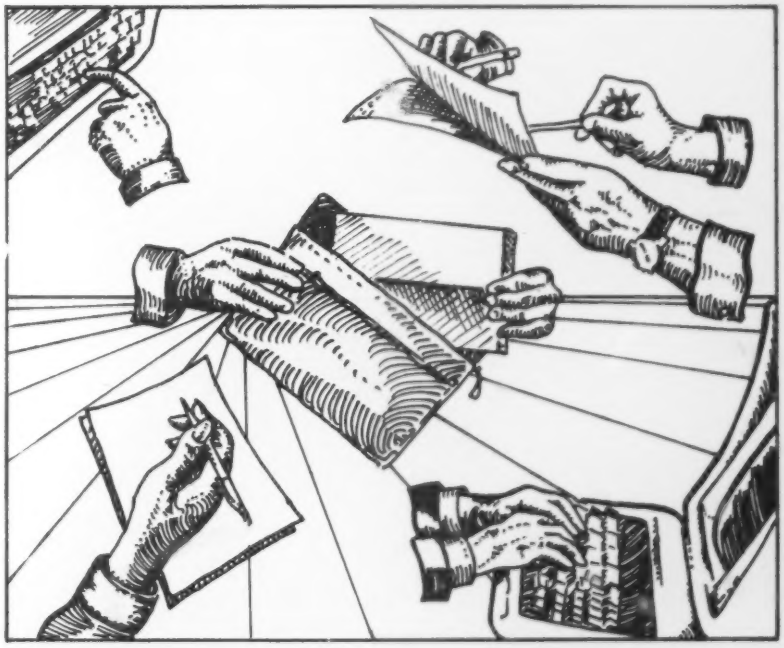
Empirically Based Recommendations for Content of Graduate Nursing Administration Programs



Cynthia C. Scalzi and David L. Wilson

Nursing administration has developed into a complex area of nursing practice, resulting in the consensus that future nurse executives need graduate preparation, with some advocating a dual degree MSN/MBA (Scalzi & Anderson, 1989). The new decade finds the health care industry, for the most part, struggling to survive.

The federal government's cost control measures continue to force further industry downsizing and consolidation. The shift to more outpatient care and the expansion of home care services are expected to continue. A competitive market has and will continue to force closures, mergers, and acquisitions of health care organizations paralleling those of other industries. These changes in the health care industry are forcing dramatic changes in the role and functions of today's nurse executives. They are being required to assume a broader scope of responsibilities as well as being expected to develop and implement programs and services that ensure the provision of high-quality patient care, reduction of costs, and an increase in productivity and retention of nursing staff.

The educational preparation of nurse managers has been determined largely by what faculties perceive to be the needs of nurse managers in acute care settings (Mark et al., 1990). Graduate nursing faculties have sought curriculum guidance from various professional organizations, such as the American Nurses' Association (ANA), National League for Nursing (NLN), Council on Graduate Education for Administration in Nursing (CGEAN), and American Organization of Nurse Executives (AONE). Surprisingly, there are few research findings on how nurse managers actually spend their time (functions) and what job activities they consider most important. Frameworks for examining nursing administration curricula published by the ANA (1988) and McCloskey et al. (1988) appear to rely on faculty consensus rather than empirical studies. Thus, the development of curricula for nursing administration frequently reflects the philosophy, experience, and acute care bias of the nursing administration faculty.

The purpose of this study was to develop an empirical basis for nursing administration curricula derived from an analysis of a survey of current job functions of top-level nurse executives in the following settings: acute care, long-term care, home care, and occupational health. The survey was designed to identify the relative amount of "time spent" and "importance" attributed to specific job activities of nurse executives. Course content areas providing preparation

Cynthia C. Scalzi, PhD, RN, and David L. Wilson, MSN, MBA, RN, are affiliated with the School of Nursing, University of Pennsylvania, Philadelphia. The authors gratefully acknowledge the W. K. Kellogg Foundation for funding this project.

Scalzi and Wilson use consensus research as a basis for determining content for graduate programs in nursing administration. They ask, what do practicing nurse executives do on the job? One hundred and eighty-four nurse executives from acute care, home care, long-term care, and occupational health rated and ranked their job functions.

Key Words: curriculum, health care, management, job function, nursing administration

for key job responsibilities are identified, and recommendations for curriculum design are discussed. Two questions were of particular interest: What type of course content is needed by all nurse executives? What content areas are unique to the particular practice setting?

Our work is based on several assumptions: (1) that understanding the functions of nurse executives in different practice settings precedes the development of a graduate curriculum in nursing administration, (2) that there is one level of graduate preparation in nursing administration, and (3) that nursing administration shares core content with other graduate nursing specializations including conceptual models/nursing theory and research methods.

Methods

Directories listing nurse executives in acute care, home care, long-term care, and occupational health practice settings were used to select a random sample. Of 300 surveys mailed, 184 were completed and returned in usable form (response rate 61%). A panel of experts in nursing administration assisted in the development and pilot testing of the survey questionnaire. The questionnaire provided a comprehensive list of job responsibilities for nurse executives in a variety of practice settings. Fifty-one activities were identified for inclusion in the questionnaire. Individuals rated each item on a scale of 1 (low) to 4 (high) in terms of "time spent on the activity" and "the degree of importance" attributed to the activity.

A second expert panel of practicing nurse managers, nursing administration faculty, and management faculty examined each questionnaire item for its educational implications. The panel assigned each item to the curriculum area that would best prepare an individual for that activity. Overall agreement on curriculum assignment was 93%. Eleven curriculum areas were identified: health care law and policy, ethics, organizational strategy, organizational behavior, quality assurance, management information systems, marketing, risk management, clinical nursing, human and material resource management, and financial management.

Results

The typical respondent was female, 40–49 years old, with 7 years of management experience, earning $40,000–49,999 annually. There were significant average salary differences between practice settings: Acute care nurse executives, on the average, earned $50,000–59,999; occupational health nurse executives earned $40,000–49,999; and home care nurse executives and long-term care nurse executives earned $30,000–39,999. Basic educational preparation in nursing was most often from a diploma school (58.2%), but the typical respondent had continued his or her education to obtain baccalaureate and master's degrees (61.4%). The nurse executives in the four practice settings differed substantially in terms of percentage having graduate degrees. Only 12% working in long-term care had a graduate degree, while 42% in home care, 55% in occupational health, and 69% in acute care had obtained a graduate degree in nursing, business, or public health administration. The distribution of respondents across the four practice settings was acute care 63 (34%), home care 57 (31%), long-term care 25 (14%), and occupational health 29 (16%). Ten respondents did not indicate where they practiced.

Scores on individual activities for time spent and importance were highly correlated ($r = .92$). Thus, time scores were used to represent the nurse executive's work role in the subsequent analysis. All 51 questionnaire items had previously been assigned to 1 of 11 curriculum content areas by the expert panel. These 11 content areas were questionnaire subscales for determining curricular score differences among the four practice settings. Curriculum scores were determined by averaging the time scores for activities associated with each educational content area. For example, the subscale or law and health care policy content area contained four questionnaire items. The time scores for these items were averaged for individuals in each of the practice settings and for the overall sample. Law and health care policy was ranked the most important content area, that is, it contained those activities rated most time-consuming and important by nurse executives regardless of practice setting. Scores for the curriculum areas, ranked by overall mean score in descending order, are displayed in Table 1.

The curriculum areas were examined for significant differences among the practice settings using analysis of variance. Significant differences were found for 6 of the 11 curriculum categories, including finance, marketing, risk management, resource management, management information systems, and clinical nursing. The top three content areas were law and health care policy, organizational behavior, and organizational strategy. This was based on their overall mean scores and the lack of significant differences among the four practice settings. That is, all respondents in this study tend to spend more time

Table 1
Ranking of Curriculum Areas by Time Spent by Practice Setting

Curriculum	Home Care	Long-term Care	Occupational Health	Acute Care	Overall Average
Law & Health Care Policy	3.07	3.01	2.74	2.90	2.95
Organizational Behavior	2.52	2.79	2.63	2.76	2.67
Organizational Strategy	2.51	2.43	2.67	2.74	2.61
Finance	2.79	*2.24**	*1.91**	2.71	2.56
Quality Assurance	2.53	2.78	2.59	2.47	2.55
Marketing	2.67	*2.20**	2.39	2.54	2.51
Risk Management	*2.31**	2.83	2.41	*2.28**	2.39
Resource Management	2.25	2.59	*2.00**	*2.12**	2.22
Management Information Systems	2.23	*1.50**	2.46	2.27	2.18
Clinical Nursing	2.26	2.55	2.17	*1.87**	2.14
Ethics	2.11	2.08	2.19	2.09	2.11

Settings with underlined scores in a curriculum area are significantly higher in their ranking than settings with italicized (and *) scores in that area.

on activities that require knowledge of law and health care policy, organizational behavior, and organizational strategy. Because of the high correlation of time and importance scores, we can also say that these nurse executives considered these activities to be very important in addition to being time-consuming. Ethics was the only content area where time and importance ratings were not highly correlated. In fact, ethics ranked second in importance but lowest in terms of time spent.

Discussion: Fundamental nursing administration content

Our findings suggest that based on time spent in various job activities, ...there is some fundamental educational content that all nurse executives need regardless of practice setting. *Health care law and policy* scored as the single most relevant content area for all four groups of nurse executives. Preparation in health care law could include relevant court decisions, legislation, federal and state regulatory activities concerning health care, such as licensure, accreditation, certification, and certificate of need processes. Health care policy content would focus on analysis and choices among health care policy initiatives employing cost/benefit techniques.

Organizational behavior and politics also scored highly, ranking in the top five content areas for each of the four groups. Content in this area could include topics such as group dynamics, change management, conflict management, and political aspects of organizational life.

Organizational strategy ranked third overall, and could include content on competitive strategies, market analysis, and organizational structure. *Finance* ranked fourth overall, and could include content in health care finance such as financial statement analysis, ratio analysis, debt financing, working capital management, budgeting, and budget variance analysis. A course of this nature could utilize computer-based techniques to teach financial analysis, demand forecasting, and workload analysis and budget construction.

Quality assurance ranked fifth overall, with no significant differences across the practice settings. Content in this area might cover the development of criteria and standards of quality, monitoring critical indicators and evaluating changes in quality over time. Evaluation methodologies should include structure, process, and outcome measures of health care quality.

Ethics ranked lowest of the 11 content areas in terms of time spent, but it also ranked second in importance. Time spent on explicitly ethical issues appeared to be low, but the ethical dimensions of health policy, organizational behavior, and organizational strategy support the inclusion of ethics as a fundamental element in nursing administration curriculum. While not a content area identified by our expert panel, we believe that an understanding of *health economics* is probably a necessary prerequisite for organizational strategy, as well as finance and marketing. Familiarity with such concepts as supply and demand, monopoly, monopsony, fixed cost, marginal cost, and economies of scale are fundamental.

Our study also identified differences in job activities across practice settings that suggest the need for different curriculum electives. In general, activities in acute care and home care are fairly similar, but occupational health and long-term care are substantially different in terms of time spent in various job activities.

Acute care and home care

Acute care and home care differ primarily in the administrative practicum site and need for a clinical elective. Each student could be placed in a practicum setting relevant to his or her career goals. Acute care nurse executives rated time spent in clinical activities so low that the need for additional clinical experience is questionable. Nurse executives in home care, however, spent more time on clinical activities, and, thus, a clinical course in community health nursing might be of value. We found that home care nurse executives have, if anything, a stronger need for financial and marketing acumen than

Table 2
Fundamental Nursing Administration Content

1. Health care law and policy
2. Organizational behavior and politics
3. Organizational strategy
4. Finance
5. Quality assurance
6. Ethical decision making
7. Health economics

Nursing conceptual models/ theory and research methods are usually considered core content for all graduate programs in nursing.

acute care nurse executives. Perhaps home care nurse executives are more like entrepreneurs than traditional nurse administrators, a trend that reflects the growth and dynamism of the home care industry.

Long-term care

Nurse managers in a long-term care setting spend more time than the other three groups in risk management, resource management, and clinical nursing activities. In addition, these nurse managers are responsible on the average for more full-time equivalent employees than any group except acute care, yet they have the lowest mean salary. Attracting nurse managers from this practice setting into graduate education will be difficult until compensation reflects the value of additional education. Because of the amount of time involved in clinical activities nurse managers in long-term care need a curriculum that is more a hybrid of gerontological nursing and administration, in which risk management and human resource management are emphasized. Time spent on management information systems, marketing, and finance appeared to be less in long-term care than in any of the other practice settings. While these findings reflect current practice, it may not be what is needed for future nurse executives in this field.

The new decade finds the health care industry, for the most part, struggling to survive.

Occupational health

Occupational health nurse managers practice in a very different environment, in that they are subject to the constraints of for-profit businesses that provide products or services unrelated to health care. Cost-effectiveness and program evaluation are essential content areas for these nurse managers (Lusk et al., 1988). Our results in terms of time spent in specific job activities suggest the need to emphasize health policy, planning, program evaluation, and management information systems. Since the typical role of the occupational health nurse executive involves a staff position without a large number of employees to manage, less content on human resource and financial management may be appropriate.

Nurse managers in different types of practice settings have different job activities and, thus, need different educational preparation. The curriculum implications suggested here reflect the realities of today's nursing practice as a logical starting point for curriculum design. But it does not necessarily represent what will be needed for nursing administration environment in the future. Current practice may be only an indication of what nursing administration has been, rather than what it needs to become. This study suggests, however, that whatever nursing administration becomes, it is different in settings that provide distinctively different services and that operate in distinctive organizational environments. Appreciation of the different sets of organizational and environmental factors is necessary for those developing curricula that are relevant to nurse managers in specialized areas of nursing practice.

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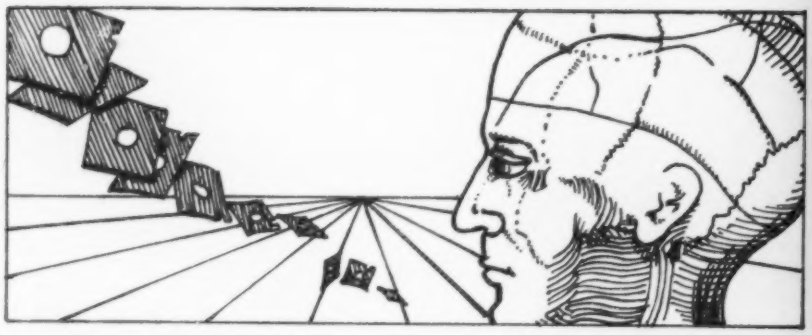
Nurse Executive Role Socialization and Occupational Image



Mary Elizabeth Krugman

Nurse executives function within a rapidly changing health care environment, one that is affected by new technological developments, fiscal restraints, corporate restructuring, and scarce resources. These changes have occurred recently and rapidly, with significant influence on nurse executive role functioning. Nurse executives, often newly titled at the vice president level, now exercise a greater span of managerial control over diverse personnel groups, direct a substantial budgetary process, and oversee compliance with intricate regulatory directives from all governmental levels.

It is not clearly understood how the nurse executive is socialized professionally into this new, visible, and powerful executive role. Nurse executive role socialization has not been studied; research provides insight into role identification, knowledge of how education preparation influences role functioning, and information about relations with nurse and nonnurse management colleagues. This article outlines the theoretical considerations of nurse executive role socialization and occupational image, and presents data collected from a nationwide survey of 386 top nurse executives.

Background

Nurse executives have been urged to be special advocates for nursing, over and above the normative health administrator role expectations (Conway, 1979), yet they have also been more recently described as possibly relinquishing this advocate position because of the marginality of their role positions. Biordi (1986) observes the female nurse executive is often part of a female minority in the hospital management structure. As a representative of a traditionally low status women's occupation, she may take on the male management values and identity to obtain role success. Added to these role demands is the need for the nurse executive to base his or her practice on a specialized and unique synthesis of knowledge from two disparate disciplines, nursing and business administration. The manner in which a nurse is professionally socialized will influence how these disciplines are integrated and the way the practice of nursing administration develops (Blair, 1989).

Socialization of the nurse executive is influenced by the type of formal educational program the nurse executive has experienced on all levels of education, since education is a primary force in the way a professional is socialized and develops an occupational identity (Pavalko, 1971). Graduate education is one of the strongest bonds for the induction into a profession, yet nurse executives come to their professional role from a variety of educational paths, many not taught within nursing. Both nurse administrators and nurse educators widely debate how the type of education experienced influences nursing administration practice. Many believe nurses educated at the graduate level outside of the profession may not be as committed to, and may not identify as strongly with, the nursing profession. Data about nurse executive education and role identification is important, for at that level of professional visibility and power the nurse must be able to clearly articulate the rationale and justification for nursing practice decision making, and be an advocate for nursing within the health care setting.

Mary Elizabeth Krugman, PhD, RN, is nursing coordinator, Community College of Denver, Denver, Colorado.

Theoretical framework and pertinent research

Since there is no unified theory of nurse executive socialization, diverse sources of literature were drawn upon to construct a theory and working model of nurse executive socialization. Symbolic interactionism, one theoretical perspective, proposes that professional self-identity develops through the clarifying responses of reference group others (Bucher & Stelling, 1977). A nurse executive thus assumes role identity through a construct of specific interactions and patterns of experiences with colleagues significant to him or her. Light (1980) views professional socialization as an interactive process, whereby the individual (nurse executive) exerts control over occupational choice and consciously decides who will serve as significant role models and reference others. Structure is perceived as a fluid and changing variable, amenable to change rather than a fixed condition. It is this theoretical understanding of professional socialization that served as a foundation for the construction of a descriptive working model of nurse executive socialization, which guided the research described in this article.

In this research, Krugman explores the effects of educational and experiential variables on the occupational image of the nurse executive. Early socialization as a nurse seems to remain a constant, and institutional management climate is another important variable.

Key Words: role socialization, occupational image, management climate, role model

Nurse executive socialization can therefore be viewed as an active, continuing process whose outcome is a nurse executive who holds a particular view of her- or himself and the work role. This self-perception is influenced by (1) work setting (Brief et al., 1979), (2) role set relations with colleagues (Miller & Wager, 1971), (3) the nurse executive's chosen reference group (Lum, 1978), and (4) the resolution of role expectations with role realities (Decker, 1985).

Nurse occupational image is a central concept to the understanding of work socialization. Haas (1964) identifies three sources in the formation of occupational image. First, the individual's perception of his or her work image will be influenced by perceptions of how worthwhile the occupation is relative to other jobs in society. This concept of relative worth includes the value society places on the occupation, and the rewards associated with carrying out the role. The second component of occupational image is a competency dimension, which includes how well the individual perceives he or she is carrying out the role. Finally, the third dimension focuses on how occupational image relates to the inherent satisfaction associated with the job, including the relationships, values, and beliefs that make the job satisfying. The nurse executive thus holds a job image that is a construct of three components: perceived job worth, perceived competency, and job satisfaction. The self-image of the nurse executive deserves special study to see whether self-perceptions of nurses who hold top management positions reflect the descriptions of low self-esteem characterizing the profession as an aggregate (Chinn & Wheeler, 1985).

Working model: Nurse executive socialization

Utilizing concepts from Hinshaw's (1976) socialization model, Haas's (1964) description of occupational image, as well as other related role and work socialization literature, variables representing the dimensions of socialization were arranged in model configuration, as a basis for research on nurse executive socialization and occupational image. Table 1 shows such a model of socialization. This model does not include stages of the process; stages cannot be developed until data is collected on a cohort group over time. The model is constructed on the theoretical premise that the way in which a nurse executive is professionally socialized into an upper management position is related to that nurse executive's occupational image.

Definition of model variables

Each of the independent, intervening, and dependent variables were defined, substantiated by the pertinent literature, and propositional statements developed. The terms are described in Table 2.

Research study

The nurse executive socialization model was tested by a quantitative instrument entitled the Nurse Executive Profile. The instrument was constructed by the author according to standard research protocol. A pilot study was conducted to test the content and validity of the instrument, and a scoring system was developed. The instrument consists of two parts: Part 1 is a 45-item Likert-type self-reporting measure; the nurse executive respondent assessed his or her perceptions of professional socialization and occupational image. The scores derived from this part can be examined by domain (variable), by a total socialization score, and/or by the occupational image score. Cronbach's alpha, computed for the total socialization score, was .849, while the alpha run for occupational image domain was .772. Both Cronbach alpha procedures show moderately high internal consistency.

Part 2 of the profile consists of 31 demographic items related to respondent professional information. These items were correlated with the self-assessment section. The instrument was sent to 640 randomly selected nurse executives who held top nurse management positions and were members of the American Organization of Nurse Executives.

Profile of nurse executive subjects

There were 386 usable returns from nurse executives in 50 states who held positions in a variety of institutions, the size of which ranged from 20 to 3,000 beds (median 336 beds). The majority of respondents were female (350, or 90.7%), Caucasian (96.6%), and 46 years of age (52.2%). Table 3 shows the educational background of the nurse executives. More than half (58.0%) of respondents held the title vice president, earned over $50,000 per year, and believed their salary to be comparable to their health care executive peers. Data were also collected on the reporting structure. The majority of nurse executive subjects (n = 362) reported to one person, who occupied the top executive position within the organization. The title of this top executive was most often described as CEO (n = 219), and 86.3% were males educated as hospital administrators or in the field of business. The majority of nurse executive respondents occupied a position with line authority equal to or greater than other hospital executive colleagues. The nurse executive subjects exercised a span of control that varied widely. Some nurse executives had only two individuals reporting to them, while other nurse executives had over 20 directors reporting, with over 50% of these representing various types of nursing personnel.

Results of study

Research on the socialization model yielded extensive data on the relation-

ships among variables. Only those findings most pertinent to nurse executive self-image will be reviewed here.

1. Who do nurse executives identify with and use as their professional reference group?

Nurse executives were asked about the kinds of professional meetings they preferred to attend, with whom they networked, whether they felt distanced from nursing now that they were in top management, with whom they interacted, and what type of journals they read. Subjects demonstrated a strong affiliation with and reference to nursing, with over 97% reading nursing journals and attending nursing meetings. Although 86.3% of these nurse executives report to males and work in a male management hierarchy, they networked and identified with nursing. These results indicate nurse executives do not lose their professional nursing identity, as Biordi (1986) suggested may occur because of their marginal role situation.

2. Do nurse executives who are educated differently show significant differences in occupational self image?

When nurse executive respondent education was correlated with occupational image score, the results (p = .791) indicated there was no significant difference between type of education (Table 3) and occupational image (perception of competence, job worth, and satisfaction). These findings suggest that nurse executive occupational image is not shaped in a particular way by type of educational program. There was a similar degree of variation in the occupational image of nurses educated at all professional levels, and in both nursing and nonnursing programs. Educational differences did assume importance in relation to the subject's perceptions about education for the role of nurse executive. When nurse executives were tested on their perception of education for the role, there were significant differences in nurse executive views of whether nurse executives should have nursing or nonnursing graduate education. Nurses who held graduate degrees in nursing believe the type of education for practice is important and should be within nursing, while nonnurse educated subjects did not hold that type of graduate education was significant. This finding indicates nursing education programs are successful in socializing their graduates into a positive perception of nursing education.

Table 1 *Working Model of Nurse Executive Socialization*

Independent Variables	Intervening Variables	
1. Reference group identification	1. Job environment	4. Mentor activity
2. Educational preparation	Management climate system	Use of mentor
Type of education	Institution type	Perception of mentor
Perception of education	Institution size	5. Gender relations
3. Demographic characteristics	Institution specialty	
Gender	Institution governance	
Age	Geographic location	
Ethnicity	2. Job characteristics	
Years in practice	Title	
4. Role expectations	Years in position	**Dependent Variables**
5. Professionalism	Salary	1. Occupational image
	Like/stay in position	Job worth
	3. Role set perceptions	Job competency
		Job satisfaction

3. Do male and female nurse executives show differences in occupational self-image because of gender?

Male and female nurse executives did not show significant differences in occupational image (p = .875). This contradicts studies by Lasky (1982) and others, who found women showed a lower work-related self-image than men. However, when test items relating specifically to gender relations in the workplace were analyzed by respondent's gender, significant differences were determined by Mann-Whitney U Wilcoxon Rank Sum Test. Results indicated male nurse executives felt they have significantly fewer gender-related interpersonal problems, and believed that female nurse executives had to work harder than males to be accepted on the management team. This analysis also revealed that the male nurse executives did not perceive they are as competent as their female nurse executive colleagues in business and marketing areas, and that female nurse executives perceived themselves to be more competent in the area of financial management than did the male nurses. These findings do not support any consistent sex-linked pattern, and lend support to Lenny's (1977) contention that differences between male and female self-image cannot be generalized, but are a specific response to a particular aspect of the work environment.

4. How does the work environment influence nurse executive occupational self-image?

Six dimensions of the nurse executive's work environments were studied: type of institution, institution specialty, size of institution, type of governance, geographic location, and management climate system. The only dimension that significantly influenced nurse executive self-image was found to be the institution's management climate. Nurses identified which of four management systems characterized their institution: exploitative authoritarian, benevolent authoritative, consultative, and participative (Likert, 1961). Nurse executives who worked in participative climates showed significantly greater job satisfaction (M = 15.785), and a significantly higher occupational image score (M = 47.7357). The participative management climate closely resembles the decentralized organization model, which has been shown to be associated with high job satisfaction (Przestrazelski, 1987).

5. Do special characteristics of the nurse executive's position influence occupational self-image?

The specific characteristics of the nurse executive job position examined in this study were job title, years in position, salary, and whether the

nurse executive liked his or her position and planned to remain in the position. The type of title used to designate nurse executive positions (executive, director, operating officer, etc.) did not appear to affect self-image significantly. However, there was a significant relationship between the nurse executive's image and his or her salary ($p < .001$). A Sheffe Test revealed nurse executives earning over $75,000 and $100,000 showed stronger perceptions of their own competency than nurses earning under $75,000 per year. Indeed, nurses earning over $100,000 per year gave more indications of job satisfaction, self-perceived competency, job satisfaction, worth, and had a higher overall occupational image score than any other income group. These results support Epstein's (1971) research, that women use the amount of salary they receive as a criterion of success in male-dominated management fields.

Whether nurse executives liked their positions and planned to remain in them also significantly affected their executive occupational images; those who liked their positions and intended to remain held significantly more positive images.

6. Is nurse executive occupational image related to perceived professionalism?

Professionalism in this study was measured according to criteria Pavalko (1971) and others have delineated as hallmarks distinguishing a professional from a nonprofessional worker: autonomous practice, actions that maintain professional values and standards, and the modeling of professional behavior to colleagues. Nurse executive subjects who reported upholding nursing values, spending time with the staff on units, and maintaining professional standards of care showed a higher occupational image than other nurse executive subjects ($r = .4457$). Nurse executives holding strong perceptions of professionalism came from a variety of educational backgrounds, demographic characteristics, and work settings.

7. How does a professional mentor relationship affect nurse executive occupational image?

In this study, 261 nurse executives had relationships with colleagues who acted as their mentors, while 120 did not. A t test between type of groups (mentor/no mentor) and occupational image score revealed there was no significant relationship between self-image and whether the nurse executive had a mentor. These findings contradict Larson's (1986) research that nurses who have mentors report higher job satisfaction. Of the nurse executives who had mentors, 54.2% reported male mentors. The nurse executive who had male sponsors did not decrease professional nurse role identification, an outcome suggested by Campbell-Heider (1986).

Summary

Nurse executives in this research study strongly identified with the nursing profession and did not show a change in reference group as they moved into top level management. Those executives who were older and more seasoned showed a more positive occupational image than the younger, less experienced nurse executives. This group of top nurse executives also maintained a strong and consistent core of professionalism that was not influenced by the type of institution, salary, gender, or educational background. This variable, professional-

Table 2 *Variables*

Independent Variables

1. *Reference group identification*: Subject's identification to a particular group; subject uses group as a frame of reference (Shibutani, 1962)
2. *Educational preparation*: Type of formal educational experiences completed by nurse executive subjects
3. *Demographic characteristics*: Descriptors that provide context to understanding nurse executive subject background
4. *Role expectations*: Norms that identify the attitudes, behaviors, and knowledge perceived to be expected for a role occupant
5. *Professionalism*: The attributes and attitudinal characteristics of nurse executive related to autonomy of practice, beliefs about standards of practice, and professional commitment (Hall, 1968)

Intervening Variables

1. *Job Environment:*
   a. *Management climate system*. The relatively enduring quality of internal environment of an organization that is experienced by members; values and attributes of the organization (Tagliuri & Litwin, 1968)
   b. *Institution type*. Characteristics of the institution, such as profit status, type of affiliation
   c. *Institution size*. The bed capacity of the institution
   d. *Institution specialty*. Whether the institution limits its service to one type specialty
   e. *Institution governance*. The form of policy control exercised by the institution
   f. *Geographic location*. Where institution is located
2. *Job characteristics*: Descriptors of nurse executive subject's position
3. *Role set perceptions*: Descriptions of how the nurse executives feel the role is perceived by other colleagues in the organization (Merton, 1957)
4. *Mentor activity*: Descriptions of relationship between nurse executives and those colleagues who act as career sponsors (Hunt & Michael, 1983)
5. *Gender relations*: Nurse executive perceptions of gender-related work role problems, issues (Fox & Hesse-Biber, 1974).

Dependent Variables

1. *Occupational image*:
   The self-conception of the nurse executive role occupant, as defined by three measures:
   a. *Job worth*. The value the subject attributes to the profession, and its relative worth to other occupations (Haas, 1964)
   b. *Job competency*. The nurse executive's self-evaluation of his or her ability to manage the position effectively (Connolly & Bruner, 1974)
   c. *Job satisfaction*. The degree of job satisfaction experienced in the role of nurse executive

Table 3 *Nurse Executive Education*

Primary Education for Practice	Number	Percent
Diploma in nursing	201	52.1
Associate degree, nursing	27	7.0
Baccalaureate degree, nursing	153	39.6
Highest degree attained		
Diploma in Nursing	11	1.0
Baccalaureate in nursing	34	8.8
Baccalaureate in other field	18	4.7
Master's in nursing	196	50.8
a. Nursing administration specialty	101	54.0
b. Other nursing specialty	95	47.0
Master's in other field	98	25.4
a. Business/health administration	60	61.0
b. Other master's (education, public health)	38	39.0
Doctoral degree	25	6.5
a. Nursing	8	2.1
b. Nonnursing	17	4.4

ism, appears to have been inculcated early in the career, possibly during the primary socialization process, since it appeared to be a stable component of the professional identity of this well-experienced group.

While there were many variables that did not affect occupational image, such as gender, title, and type of institution, it is important to highlight the significance of management climate in shaping the nurse executive's self-image. The strong association between positive self-image and the participative type of management system indicates that this climate provides opportunities for professional autonomy that reinforce nurse executive's feelings of competency and positive self-worth. Nurse executives in this environment see themselves as active and powerful players in shaping the organization. It must be recognized, however, that these executives may possess traits that drew them into that type of management climate, while executives with less dynamic traits may be drawn to climates that foster a more passive view of their role and influence. Since type of management climate is so strongly linked to perceived competency and job satisfaction, the findings would suggest that all types of graduate programs preparing nurse executives should include a strong curricular component that teaches skills related to assessment of the climate, interpersonal group dynamics, and team building.

Nurse executives hold a pivotal role in the health care industry. This study's findings shows them to be strongly identified with nursing, possessing an independent core of professionalism, and holding occupational image sensitive to the type of institutional management climate. The study clarified the dimensions of nurse executive self-reported socialization, and suggests areas for further research, particularly on gender relations, educational preparation for the role, and mentorship.

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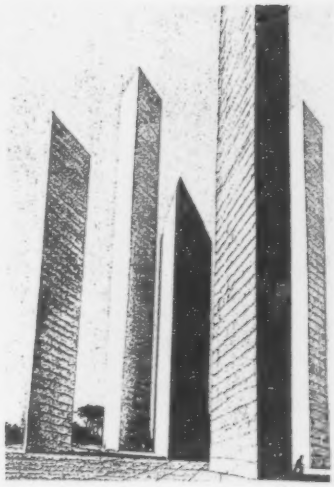

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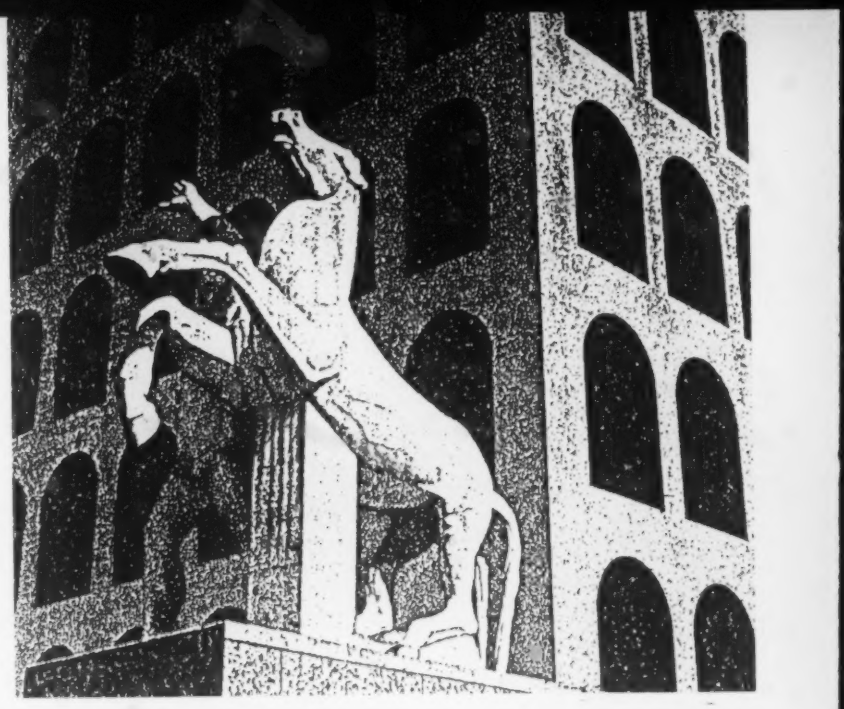
Health Care Under Siege:

Challenge for Change



Patricia L. Starck

Health care in the United States is dominated by fee-for-service payment to doctors, third-party payers motivated to conserve their funds, and consumers who are largely unaware of costs (Enthoven & Kronick, 1989a). There is little or no incentive to find more economical means to achieve health outcomes.

Ethical indictments. In our progressive nation, which prides itself on its ingenuity, health care costs and quality remain enigmas. Serious ethical indictments of our way of providing health care are replete in the literature. The following ten indictments characterize our present state of affairs:

1. Citizens do not enjoy a basic right to health care: 37 million U.S. citizens do not have health insurance of any kind (Health Insurance Association of America (HIAA), 1989).

2. Our present system of financing health care is inflationary, unfair, and wasteful (Enthoven & Kronick, 1989a).

3. The U.S. health care economy is a paradox of excesses and deprivation (Enthoven & Kronick, 1989a).

4. The present system is characterized by intergenerational (Callahan, 1987) and socioeconomic inequities.

5. Rationing is both pervasive and irrational, based on who can pay (Frech, 1988).

6. There is a bias toward acute care medicine and high technology even without scientific evidence of superior results.

7. Prevention, health promotion, and long-term care are woefully inadequate.

8. Whereas in most industries technology promises a better product at a lower price, health care technology is responsible for runaway costs (Frech, 1988).

9. In spite of increasing costs of hospitalization, hospitals are closing at an astonishing rate. It is predicted that 40% of existing hospitals will close or convert to another purpose by the year 2000 because of financial failure (HIAA, 1989).

10. Health insurers want to insure those persons who are least likely to need medical care, and to protect themselves and their policy holders from covering the costs of the very sick (Enthoven & Kronick, 1989a).

The problems of macroallocation. At the macrolevel, the question is, "How much of the national budget should be spent on health care?" Americans have not asked that question; rather, the costs are totaled at the end of each year, and each year the costs continue to climb. In the United States, approximately $1.5 billion per day is spent on health care (HIAA, 1989).

The percentage of the gross national product (GNP) spent on health care has been steadily rising over the past several decades, from 4.4% in 1950 to 11.2% in 1987 (HIAA, 1989). It is projected to grow to 15% by the year 2000 (Enthoven & Kronick, 1989a).

A significant portion of the GNP (3%) is spent on the elderly, and 1% of the GNP is spent during the last year of life (Callahan, 1987). Of the total GNP spent on health care, 40% is spent on hospital care (HIAA, 1989). The United States spends more on health care than any other developed nation (see Table 1). In 1986, Japan and the United Kingdom spent approximately one-half the U.S. amount.

Furthermore, the amount spent does not seem to increase overall life expectancy. Life expectancy for Japanese males in 1986 was 75.9 years compared to 71.4 years for U.S. males.

The macroallocation process is failing to provide health care for all citizens at even the minimum level. In 1989, the 37 million uninsured Americans amounted to 17.5% of the U.S. population, excluding those over 65 years who are covered by Medicare (HIAA, 1989). Moreover, nearly 50% of the uninsured are working, usually at minimum wage. Of the remainder, 33% are children and 17% are unemployed (HIAA, 1989).

Who pays the bills for health care? In 1987, health care was financed by 41% public spending and 58.6% private spending.

Of the total GNP, 40% is spent on hospital care; yet U.S. hospitals are having serious financial troubles.

Patricia L. Starck is professor and dean, School of Nursing at the University of Texas Health Science Center at Houston. This article is adapted from a convocation speech at Georgia Southwestern College, Americus, Georgia, October 25, 1989.

National health care: It ought to be a plan, not an accident. Starck compares how it is with how it ought to be. She assesses the predominant problems of AIDS, elder care, and organ transplant. She also makes a case for national health planning. *Key Words: health care policy, costs, economics, ethics, access to care, elderly, AIDS, organ transplant, rationing*

Despite the growth of hospital expenditures at a much faster rate than the GNP, the number of hospitals has risen only as fast as the population. In 1950, the average cost of a hospital room was $16 a day; in 1975 it was $152 (Frech, 1988). In 1987, the U.S. average cost in a community hospital was $538.96 per day (HIAA, 1989). Even so, hospitals are going broke. Hospitals have come under increasing financial pressure and thus are developing strategies to avoid caring for those who cannot pay, such as closing emergency rooms (Enthoven & Kronick, 1989a).

Microallocation. Presently, no predeterminations have been made for how much should be spent for acute care, chronic care, prevention, health promotion, or rehabilitation. No decisions have been made on how much to spend for the rising incidence of cancer, nor for the decreasing incidence of cardiovascular disease. There are no goals for expenditures for infants, youngsters, adults, and the elderly. The cost effectiveness of technology has not been adequately analyzed. At the microlevel, there are many areas of runaway costs. This article will examine three:

1. Persons needing transplants.
2. Persons with Autoimmune Deficiency Syndrome (PWA).
3. Elderly persons needing care.

Transplants. Transplant technology in this nation is unsurpassed. The human body has 27 donable organs and tissues. There is a shortage of donors: one third to one-half of patients needing transplants die while waiting. There are four times as many people needing kidneys as there are available kidneys. At the Texas Medical Center (TMC), there are over 200 patients at any given time waiting for a transplant. Only 10%–14% of the estimated 23,000 brain deaths per year result in organ donations. Table 2 shows four types of transplants, the number of them performed in 1988, the survival rate (defined in terms of one year after transplant), and the costs.

In the field of organ transplants, there is an ethical supply and demand problem. Organs are rationed on the ability to pay; patients must pass the "green screen." There is competition between foreigners and U.S. citizens for organs. Many wealthy foreigners come with cash in hand. Since the voluntary approach to organ donation has failed to provide the number needed, "required request" legislation has been considered to allow harvesting of organs unless denied (Coolican, 1986).

PWAs. There is a growing fear that the financial burden of caring for Persons with Autoimmune Deficiency Syndrome (PWAs) will become overwhelming and compromise other services needed by the public. Medicaid is assuming a heavy share of the burden to pay as PWAs are denied insurance or lose their jobs. Medicaid's budget is currently expending 25%–40% on PWAs. In 1986, Medicaid spent $2.3 billion on PWAs; in 1991, it is projected to spend $47 billion (Scitovsky, 1988). In February, 1989, there were 87,300 cases of Autoimmune Deficiency Syndrome (AIDS) and 49,976 deaths attributed to AIDS (HIAA, 1989). Furthermore, the Center for Disease Control predicts that in 1992, the number of new PWAs will exceed the cumulative total diagnosed from its inception through 1988. The 1992 total is expected to be 172,000 (Center for Disease Control (CDC), 1988). It is estimated that 1.5 million Americans are already infected.

New York is currently the city with the most Human Immunodeficiency Virus (HIV) infected persons. AIDS is now the leading cause of death among men 25–44 and women among the ages 25–34. Fifty percent (50%) of the IV drug users in New York are HIV positive and 400,000–500,000 New Yorkers have been infected. In 1987, 4000 AIDS patients took up 5% of the acute care hospital beds. This number is estimated to climb to 25%–40% of all acute care beds by 1991 (Weinberg & Murray, 1987). The AIDS babies are often "warehoused" in hospitals at the rate of $1000 per day in neonatal special care units (Meintz & Lynch, 1989).

The Elderly

In 1985, for the first time in U.S. history, the number of persons over the age of 65 exceeded those under the age of 18 (Callahan, 1987). The aging of the "baby boomers" in the next few decades will further strain the health care system. Between 1980 and 2000, the population is expected to grow by 18%, but the functionally dependent will grow by 38% to 15 million (Aiken, 1989). Projections by the agency Health Care Financing Administration (HCFA) are that by the year 2050, there will be 69 million people over the age of 65 eligible for Medicare, of which 15 million will be 85 or older (Rech, 1988). People over age 85 make up the fastest growing age group. Currently comprising 1% of the population, they are projected to make up 5% by 2050 (Callahan, 1987).

In 1985, the elderly comprised 11% of the U.S. population and accounted for 29% of the health care expenditures. In 2040, Callahan (1987) predicts, the elderly will comprise 29% of the population and account for 45% of the health care expenditures.

Callahan (1987) expressed his view that intergenerational equity is an economic and social issue. Problems include the large amount of health care spent on the elderly, the disproportional amount spent during the final phase when death is eminent, and the expenditures of research and development of technology for the elderly. Callahan stirred much controversy in his position of setting

limits for elderly health care, promoting a natural life span and a tolerable death. Fries (1983) specified the goal as a compression of morbidity, i.e., to promote health throughout life and delay or compress the disease onset until the very end of life.

Private insurance is still in its infancy. . .

An example of technology re-directed to the elderly is the end-stage renal disease program, which was originally intended to provide life-saving care to young people and working age adults in the prime of their productive lives. Five years after it was instituted, more than 20% of recipients were the retired and elderly (Rettig, 1980).

In the United States, there is no age limit for recipients; however, in the United Kingdom the limit is age 55 years for government coverage. In 1984, end-stage renal disease programs cost $2.1 billion in the United States. In 1974 there were 16,000 beneficiaries; in 1984 the rate had grown to 87,000 beneficiaries (HIAA, 1989).

Another high cost of health care for the elderly is institutional care. U.S. nursing home expenditures for 1987 totaled $40.6 billion (HIAA, 1989). The burden of this cost rests with two main sources—the patient and family and state taxpayers who fund the Medicaid program.

Private insurance is still in its infancy... (Frech, 1988). By the year 2000 these expenditures are expected to increase by 47% from 1987 levels (Callahan, 1987).

Ethical and economic solutions

This section focuses on principles of ethics and the goals of an ideal health care system. Economic considerations are presented in three models.

Ethical considerations.

Ethics, as a branch of philosophy, is an applied science. The science of ethics continually evolves as new and ever more difficult situations arise. However, ethical principles remain constant. The three basic principles of ethics focus on:

1. Beneficence. The production of good and prevention of harm. The continuum of good to harm allows for some risk. The risk is known as "informed consent." The principle of beneficence asks "Is it good? Is it more good than harm?"
2. Justice. The fairness of the distribution. Is it just? Is it fair? Who can live when not all can live? Are people treated equally?
3. Self-determination. The right to choose one's course of action. Is it respectful of human rights? Freedom of choice is a very strong American value.

There are two basic approaches to ethics: rule ethics and situation ethics.

1. Rule or deontological. The standard of right and wrong is the rule or law: "We must always tell the truth, keep our promises, etc." Decisions should be made according to the rule, not the goodness or badness of its consequences.
2. Situational or teleological. The purpose or meaning is important. The most well-known type of teleological ethicist is the utilitarian who seeks the greatest good for the greatest number. This approach is sometimes referred to as the "ends justify the means." Another type of situational ethics emphasizes love or *agape* within the situation (Fletcher, 1954, 1966, 1967, 1979).

Within this nation we have no clear ethical system. We sometimes abide by the rules; other times, we decide according to the situation at hand.

Engelhardt (1986), a medical ethicist at Baylor College of Medicine and Rice University, identified four goals of a just health care system (however, he found it an almost impossible challenge to design a system to meet all four goals).

These goals are:

1. The provision of the best possible care for all.
2. The provision of equal care for all.
3. Freedom of choice on the part of health care provider, and consumer.
4. Containment of costs.

Problems with an ideal system.

The problem with the goals of an ideal system is that there is a conflict between justice and equality. The resources one could use to aid those in need are often already owned by other people. Individuals in a free society have a right to private property. The government cannot force the selling of wedding rings in order to feed the hungry. In a free society, citizens can choose to give their money to feed Odie, the sperm whale, instead of feeding the poor.

Engelhardt (1986) identifies the concepts of natural and social lotteries as part of the dilemma. The natural lottery is the change in an individual's fortune that is the result of natural forces such as "good genes."

The natural lottery creates inequality and disadvantages for some without creating an obligation on the part of others. In the social lottery, some accumulate wealth, and some grow poor. If people lose at the natural lottery but win at the social lottery, they can purchase health care for their problems. The ones who lose at both the natural and social lotteries are presently those who fall between the cracks in the existing health care system.

Engelhardt (1986) uses the teleological approach to fairness in delineating the unfortunate from the unfair events. It is "unfair" when injuries and diseases are due to the action of others without the consent of the victims. Lawsuits usually follow to fix blame and exact compensation.

Table 1
Comparison of Percent GNP on Health Care, 1986

U.S.	11.7%
Sweden	9.1%
Canada	8.5%
Netherlands	8.3%
Germany	8.1%
Switzerland	8.0%
Japan	6.7%
United Kingdom	6.2%

Source: Health Insurance Association of American, 1989

In a free society, all needs cannot be translated into claims against the resources of others. Needs, much less desires, do not create rights to the services or goods of others. It is not like feeding the hungry and providing shelter to the homeless because it only takes a limited amount of food and shelter. An infinite amount of resources can be committed to the

preservation of life.

Neither can everyone be allocated an equal amount of money for their health expenses: Some would have too much, other would have too little. Therefore, Engelhardt (1986) concludes that humans are destined to live lives of unequal scope and fulfillment due to: (1) the natural and social lotteries, (2) private entitlements, and (3) free choice.

However, Engelhardt (1986) recognized that societies need health care systems to "blunt the outcome of the blind forces of nature through the rational planning of human beneficence." Health care systems help to insure against losses in the natural lottery; they relieve society to some extent of fears of disease, death, and deformity.

Table 2
Transplants: Numbers and Costs, 1988

Type	Number	Survival	Costs (in $1,000s)*
Heart	1,647	80%	150–200
Liver	1,680	65%	238
Kidney	9,123	96%	30 (same as 1 yr. of dialysis) Medicare pays 7
Pancreas	243	40%	40

* Plus $12,000 per year for immunosuppressant drugs.
Source: Organ Donor Center, 1989

Economical considerations.

There are three fundamental approaches to financing a health care system: free enterprise, a socialized system, or some modification of the two.

Free enterprise. A free-enterprise system relies on the market alone to effect supply and demand, to ensure quality and cost efficiency. However, health care is not a highly market-oriented industry for many reasons (Frech, 1988). Evans et al. (1989) concluded that the competition and the market place theme of the 1980s has been even less successful in containing the growth of health care expenditures than the regulatory attempts of the 1970s. A system that relies on the market alone will not provide a social safety net for those who lose in the natural and social lotteries.

Socialized system. A socialized system purports to provide equal care for all at public expense. This mode, often referred to as "socialized medicine," has universal access or equal care. Costs could be controlled based on a governmental system. No one could purchase extra care, although this would probably result in a black market.

Many countries have what is referred to as "socialized health care," and there are various opinions about its effectiveness and efficiency. Canada has had nearly 20 years of experience with its system of universal comprehensive coverage with substantially lower expenditures than those in the United States. In 1987, Canada's share of the GNP spent on health care was 8.6%, where it stabilized (Evans et al., 1989), which can be compared to the United States rate of 11.2%.

The difference in the United States and the Canadian systems lies in three areas (Evans et al., 1989):

1. Insurance overhead. The costs of running the U.S. payment system (costs of prepayment and administration) in 1985 was $95 out of $1,710 per person. In contrast, Canada spent $21 (Canadian dollars). The United States spends $26 per capita for administration of Medicare and Medicaid alone.
2. Payments to hospitals. In Canada, the motivation is to keep hospital beds empty; in the United States it is to keep them occupied.
3. Payments for physicians' services. In Canada, physicians are paid on a fee-for-service basis according to a fee schedule negotiated between each province and its medical association (Enthoven & Kronick, 1989b). In the United States there are fewer regulations to control fee-for-services.

In insurance overhead, savings occur from: estimating risk status, allocating shareholder profits, marketing expenses, collecting payment, determining coverage, eligibility, and benefits, handling claims, handling the flow of paperwork, and reimbursing the patient or provider.

Furthermore, the U.S. insurance system creates accounting costs for the provider to comply with requirements for documentation by different insurers, direct billing, and collections. It has been estimated that these provider costs amount to $21.4 billion per year (Evans et al., 1989). Canadian physicians do not have this overhead expense or the worry of uncollectible accounts.

Additional private insurance for hospital and medical care in Canada is prohibited for services included in the private plan. This prevents private firms from skimming off the good risks and having two classes of health care.

Modified combination. In essence, the United States now has a free enterprise system combined with socialized care. Medicare and Medicaid are funded at public expense as are the military health services.

In essence, the United States now has a free enterprise system combined with socialized care.

A well-designed proposal for a modified, combined approach to financing health care is known as the Consumer Choice Health Plan (CCHP) for the 1990s. Enthoven and Kronick (1989a, b) at the Graduate School of Business at Stanford University have developed an employment-based system for national health care. Their work has been supported by the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation.

The goals of the CCHP, which features "nearly universal coverage," are:

1. To provide financial protection for health care expenses to all.

2. To promote economical financing and delivery arrangements through cost-conscious consumer choice.

This proposal is designed using incremental change, based on the fact that most of our country's health coverage is based on employment.

In conclusion, the U.S. health care system is sick and rapidly running up intolerable bills.

Medicare and Medicaid would stay the same at first. The plan uses managed competition with mixed public, state-level, and private sponsorship. The care would be subsidized at the 80% level, with the individual paying 20% unless the individual is at 150% of the poverty level. Employers would be required to cover all full-time employees and their dependents who are not otherwise covered, and to finance this through an 8% payroll tax on the first $22,500 of wages and salaries. Self-employed persons, early retirees, and others not covered by full-time employment would be taxed 8% via income tax.

Consumers would choose among qualified health plans, both for profit and nonprofit, to include basic benefits. The intent is to encourage the development of cost-effective managed care plans.

The Congressional Budget Office has estimated the efforts of this proposal on coverage, costs, and public sector budgets. It is "budget neutral" and would not affect the federal deficit. The cost would be approximately $2,400 per family per year.

In a different approach, Engelhardt (1986) noted the advantages of establishing a Two-Tiered model. The first level would provide a decent minimum level of health care to everyone, rich and poor alike.

The second level would provide an option for additional care to be purchased by those who could afford it. Some might find objectionable the idea that the rich could purchase care not available to the poor. However, Engelhardt (1986) emphasized that there is a trickle-down benefit.

Engelhardt (1986) believes this approach meshes with U.S. values: The Two-Tiered model does not deny a place for U.S. ambition and for the desire to acquire material resources.

The Two-Tiered model allows for free choice, provides an equal basic level of care for all, and allows those with more resources to purchase additional care if they wish.

Comparison of the Canadian Plan, the Consumer Choice Health Plan, and the Two-Tiered model is made using Engelhardt's four goals of an ideal system.

No plan meets all four goals. The Canadian Plan meets the goal of best care within economic limits. It provides equal care and is cost conscious. However, choice is limited by certain constraints.

The CCHP meets the best of health care goal with equal coverage for all. It is designed to be cost conscious with a large share of costs being sustained by employers. However, choice on an individual consumer level may be limited because of managed care contracts.

The Two-Tiered model encourages continued research and development to maintain the goal of best care. It would provide a level of general care equally. Those who could afford it could have a choice within the second tier, but not within the first tier. It is cost-conscious from the standpoint of general care and depends on free enterprise for the second tier. Thus, no model is capable of perfectly satisfying all goals of an ideal health system.

Conclusion

In conclusion, the U.S. health care system is sick and rapidly running up intolerable bills. Projections are that it will get worse. As responsible citizens who have ethical concerns for fellow human beings as well as for future generations, Americans must face existing problems and make the tough decisions that are required. Ethics and economics are considerations in finding long-term solutions. While there may be no perfect model that fully meets the ideals of best care, equal care, free choice, and cost-consciousness, action is required to begin the trajectory of humane and cost effective health care for U.S. citizens.

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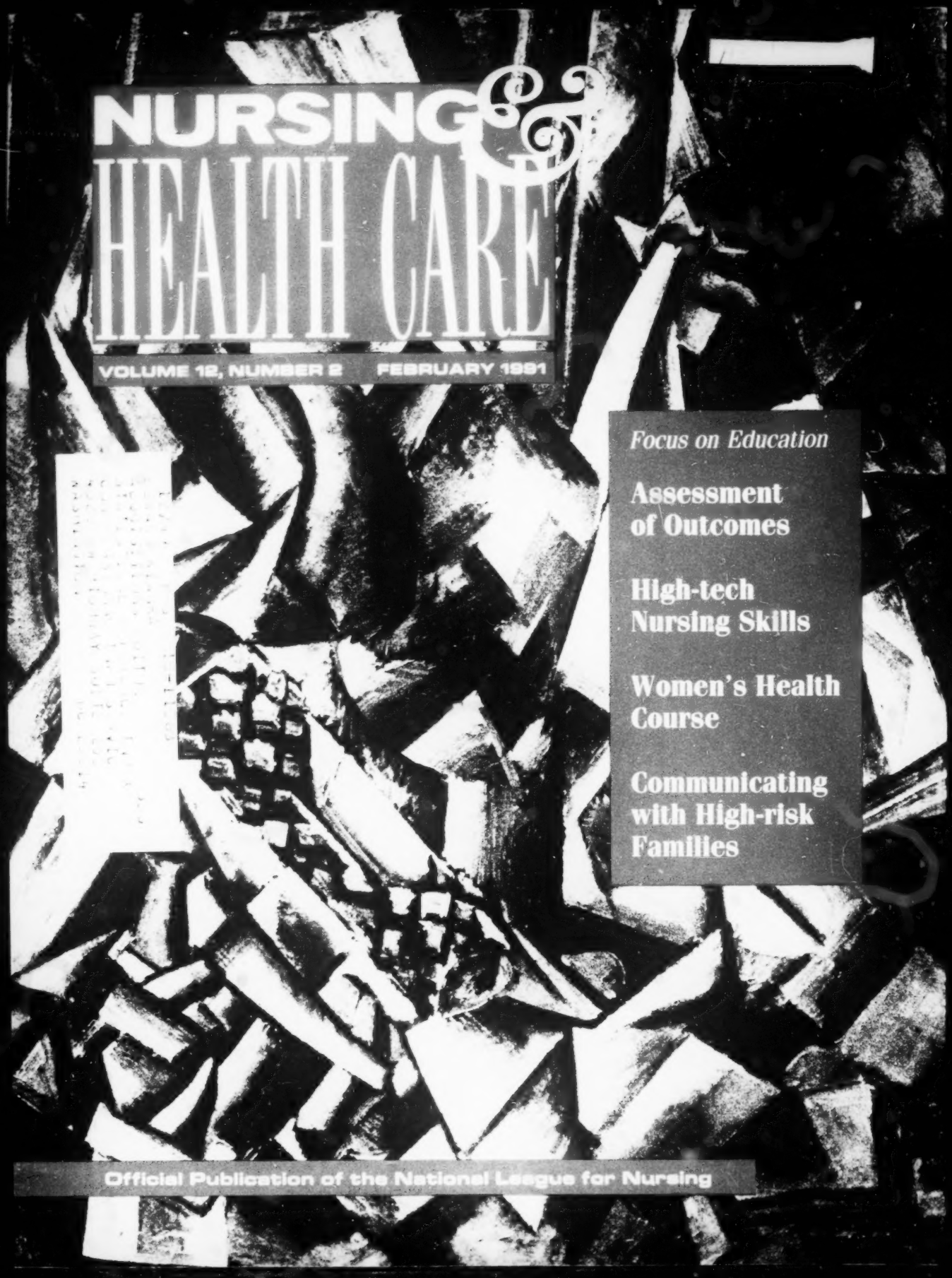

NURSING & HEALTH CARE

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Focus on Education

Assessment of Outcomes

High-tech Nursing Skills

Women's Health Course

Communicating with High-risk Families

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FEATURES

Assessment of Outcomes: The Design and Use of Real Simulation Nursing Performance Examinations 68
Carrie B. Lenburg and Carol Ann Mitchell

The authors feel that assessment of student outcome is necessary, and use their experience with the New York Regents External degree programs to back up their philosophy.

A Women's Health Course with a Feminist Perspective: Learning to Care for and Empower Ourselves 76
Susan Boughn

The author describes such a course as a "strategy in dealing with what has been referred to as the central dilemma of U.S. nursing, 'the order to care in a society that refuses to value caring.' "

Nursing Skills Necessary for Competency in the High-tech Health Care System 92
Marianne Neighbors, Evelyn K. Eldred, and Margaret Sullivan

Nurses will have to keep pace with advances in health care technology, say the authors. "Technical devices and complicated procedures will not dissipate," they write. "They will only increase as scientific advances continue."

Helping Nursing Students Communicate with High-risk Families: An Educator's Challenge 98
Helen Lerner and Mary Woods Byrne

It's the authors' contention that problems in communication and resistance by clients, as well as unfamiliarity with maternal care skills, offer a challenge to students who care for high-risk families during their maternity experience.

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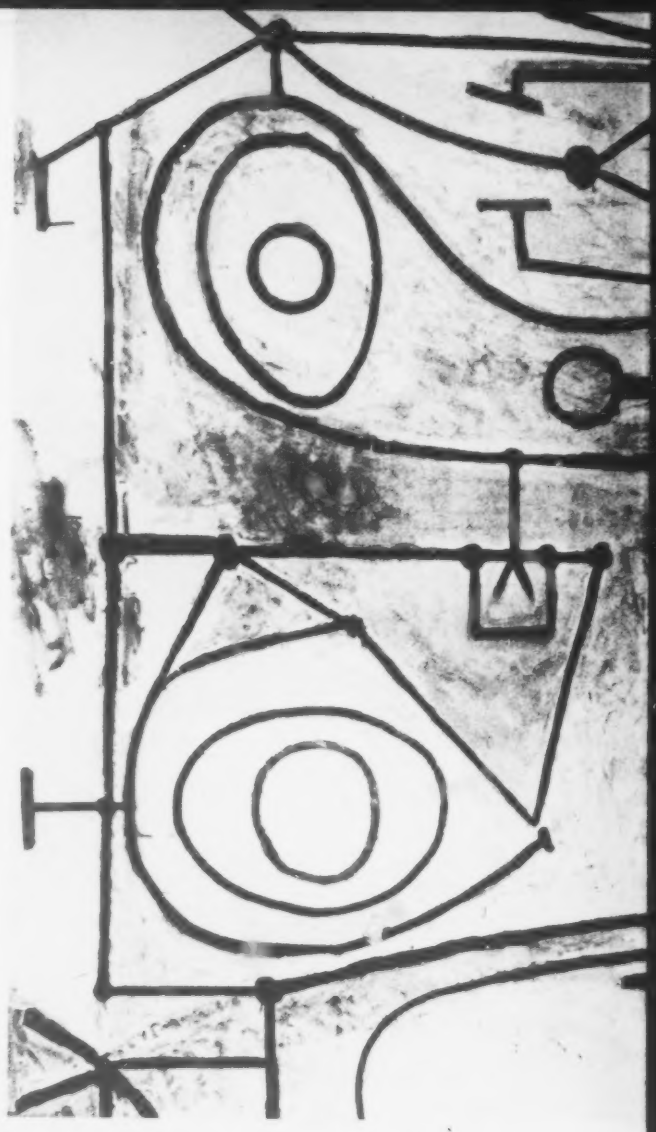
Nursing Skills Necessary for Competency in the High-tech Health Care System



Neighbors, Sullivan, and Eldred tell us how schools of nursing and institutions of nursing practice conform—or fail to conform—in regard to what constitutes basic nursing procedures. Are schools leaving the new graduate unprepared for everyday practice? A survey of association degree schools is revealing.

Key Words: procedures, technology, competency, nursing practices

Marianne Neighbors, Evelyn Eldred, and Margaret Sullivan

Technology around the world, especially in the health care field, has increased significantly in the past decade. With the intensification of technology, the skills performed by nurses have been influenced correspondingly. Traditionally, high-tech skills were introduced and performed only by nurses who worked in intensive care units or other specialized departments within the hospital. Now it is commonplace for complicated procedures and equipment to be an integral part of the ongoing care of patients in general care units of hospitals, clinics, and in the home (Bowyer, 1986; Mallison, 1988). The expectation for nurses to execute complex skills will become more intrinsic to practice if current economic, social, and technological forces persist (Malila, 1987).

Nierenberg (1987) has suggested that the nurse educator's role has changed because of technology and that educators should become more responsive to the educational needs of those in the care-giving role. While Malila was promoting continuing education as a means to acquire new skills and knowledge for practice, and Nierenberg was emphasizing creative approaches in educational methodology, both are urging that change is needed in nursing education.

Marianne Neighbors, MEd, MS, EdD, is an assistant professor. Evelyn K. Eldred, EdD, MSN, BSPHN, and Margaret Sullivan, MEd, MN, EdD, are associate professors. All are members of the Department of Nursing, University of Arkansas, Fayetteville.

What skills are needed?

There has been an ongoing discourse between nursing service and nursing education about what skills are needed by new graduates and the acceptable level of technical proficiency necessary (Kieffer, 1984). It is probably safe to say that whatever the list might be, there will never be total agreement. Special circumstances

from one setting to the next, new knowledge, continuous discoveries, and variations in technical equipment place the list in flux. Regardless of these constraints, there is still a burden upon the profession to ferret out what is currently needed by the neophyte for competent practice. In this, the first of a two-part study, associate degree programs were queried about the teaching of complex skills in basic preparation programs for nurses. As a second phase in the study, programs preparing nurses with a baccalaureate degree are being asked to report data about these same skills.

To identify the nucleus of complex skills, practicing nurses participated in developing a list of skills needed for current practice. Criteria for inclusion were those techniques commonly performed by nurses in the clinical setting having one or more of the following characteristics: complicated in nature, needing sufficient knowledge to execute safely, and/or requiring the ability to manipulate technical/electronic devices. Nursing skills such as personal hygiene, bed making, enemas, etc. were intentionally omitted. The exclusion of these skills was purposeful, not because they are unimportant but because they are considered traditional to basic curricula, and are often performed by nonprofessional care givers. Fifty-four items were specified by nurses in the practice setting as requiring complex knowledge and skill to perform adequately (Table 1). This list served as the basis for the questionnaires structured to ascertain whether associate degree nursing programs were providing the opportunity to learn these skills and to gather opinions from nursing service about the level of proficiency expected of new graduates for these skills. No limitation was placed on service respondents with respect to a differentiation in the level of proficiency expected and the type of basic preparation new graduates had completed.

What degree of proficiency is needed?

A questionnaire was then developed to survey the opinion of practicing staff nurses and nurse executives. Ten percent of the full-service hospitals located in Arkansas, Kansas, Louisiana, Missouri, Oklahoma, and Texas were randomly selected to provide the pool of respondents from nursing service. Of those hospitals represented in the study, 57% were located in settings of less than 25,000 population; 81% had less than 250 beds; and 95% provided general services. Survey packets were mailed to executive nurses of the selected institutions with a cover letter asking them to complete a questionnaire packet and to distribute separate packets to general staff nurses directly involved in delivery of care to clients in nonspecialized units of these hospitals. The number of questionnaires directed to staff nurses in the study was based on client bed capacity of the hospital: three questionnaires for bed capacity less than 100, five for 100–249, seven for 259–499,

Table 1 *List of Techniques on the Survey*

- Assessment—total (head to toe)
  - Heart sounds
  - Lung sounds
  - Abdomen
  - Neuro
- Venipuncture, adult and pediatric
- Administering IV medication
  - Piggyback
  - Direct
  - Heparin lock
- Interpretation of lab data
  - Blood gases
  - Chemistry
  - Serology
  - Urinalysis
- Nasogastric intubation
- Cardiac monitoring
  - Application of leads
  - Interpretation of rhythms
  - Administration of drugs to correct arrhythmias
- Subclavian dressing change
- Body substance precautions/isolation procedures
- IV controllers
- IV site care/changing tubing
- Accuchecks (blood glucose levels)
- Sterile suctioning/endotracheal/tracheal
- Care of chest tubes/equipment
- Use of "special care" beds
- Advanced life support measures
  - Defibrillation
  - Medication administration
- Use of doppler
- Arterial lines, Monitoring and care of Perform arterial puncturing
- TPN
- Hemovac/drains
- Multiple IV lines
- Specimen collections (sputum, stool, smear)
- Blood and blood products administration
- Chemotherapy administration
- Lavage/gavage
- Use of computers
- Wound irrigation
- Sterile dressings, packs, etc.
- Set up central venous pressure Monitor central venous pressure
- Set up ventilators Monitor ventilators CPAP/CPEEP
- Set up hemodialysis Monitor hemodialysis
- Administer peritoneal dialysate
- Monitor intrauterine contraction pressure
- Attach internal fetal electrodes Monitor FHR internally
- Monitor FHR externally
- Administer hyperalimentation
- Administer IV meds
- PCA pumps
- Discharge planning

and nine for those greater than 500 beds. Each participant in this sector of the study returned questionnaires under separate cover.

One hundred sixty-seven staff nurses and 53 nurse executives (41% and 32% response rates, respectively) responded to the questionnaire by classifying the expected level of proficiency for the new graduate according to one of the following categories: Can Perform Without Supervision, Can Perform With Supervision, Should Have Knowledge of But Does Not Need to Perform, or Does Not Need Knowledge or Need to Perform. Nurses in the practice setting, whether staff or executive, tended to agree that all procedures were important to current practice for the beginning nurse at least having knowledge of the entity.

It is interesting to note that there were 31 techniques wherein nurse executives reported 100% agreement that the beginning nurse should have, as a minimum, introductory knowledge about these skills (Table 2). In like manner, staff nurses reported agreement on 24 items (Table 3). The remaining items that fell below the 100% value were also unusually high. Beliefs were reported at ranges between 73%–90% for nurse executives, and 80%–99% for staff nurses with respect to the need for having at least a knowledge base about the entity when starting the practice of nursing.

Are educators providing learning opportunities?

All associate degree nursing programs in the six states included in the study were asked whether they provided any learning experience for these techniques. Eighty-one out of 112 programs responded to the questionnaire, giving a 72% response rate. These programs did not fare so well when it came to verifying that these skills were taught. Looking at the responses from another perspective, there were only five items where all three categories of respondents had total agreement. Skills in this group included: intravenous piggyback medication, intravenous site care, body substance precaution/isolation procedures, hemovac/drains, and sterile dressings. These might be recognized as being common to nursing practice for a number of years. It is also possible that they have been around long enough to be accepted as integral to nursing curriculum. There were only 11 skills where there was unanimous report that the student had learning involvement either by way of classroom introduction or clinical exposure (Table 4). What is more striking is that 18 of the skills are not being included by at least 27% of the schools in the study, with 9 of them being excluded from the formal curricula of half or more of the programs (Table 5). In contrast, nursing service cohorts revealed by 73% or greater that these same skills were important to the new graduate to some degree in the practice setting, as can be seen in Tables 2 and 3. Techniques that fell into this category were the following: life support/defibrillation, performance of arterial puncture, set-up of central venous pressure, set-up and monitoring of ventilators, set-up and monitoring of hemodialysis, administration of peritoneal dialysate, and the attachment of internal fetal scalp electrodes.

Nursing educators have typically taken the position that they are unable to teach everything the nurse needs for the caregiving role. It might be said that many educators believe that if the students learn the "basics"

and have developed an analytical approach to new situations, they will be able to cope in the work-world. While there may be merit in certain aspects of the educators' stance, nursing service has found it necessary to help new graduates become acclimated to the barrage of technology and complicated procedures they will face. This has been done through orientation periods of variable length, assignment to preceptors, and placement in less intense settings prior to assuming full responsibilities. The data found in this study support the notion that educators should take a renewed interest in curriculum with reference to the type of skills to which students are exposed, and will subsequently need when they graduate.

Table 2 *Skills with 100% of respondents stating the minimum needed is introductory knowledge*

Skill	Nurse Executives (%)		
	Can perform without supervision	Can perform with supervision	Should have knowledge of but does not need to perform
Assessment—total (head to toe)			
Heart sounds	73	21	6
Lung sounds	78	20	2
Abdomen	80	18	2
Neuro	80	18	2
Venipuncture, adult, and pediatric	58	39	4
Administering IV medications			
Piggyback	81	17	2
Direct	77	21	2
Heparin lock	75	23	1
Interpretation of lab data			
Blood gases	48	40	12
Chemistry	60	31	10
Serology	64	27	10
Urinalysis	64	27	10
Subclavian dressing change	53	40	8
Body substance Precautions/isolation	96	2	2
IV site care/changing tubing	93	6	2
Accuchecks (blood glucose levels)	70	26	4
Sterile suctioning/ Endotracheal/tracheal	66	30	4
Care of chest Tubes/equipment	42	53	6
Use of "special care" beds	26	57	18
Use of doppler	44	37	19
Hemovac/drains	64	31	6
Multiple IV lines	55	36	9
Specimen collections (Sputum, stool, smear)	89	10	2
Blood and blood products administration	64	30	6
Lavage/gavage	64	26	9
Wound irrigation	57	38	6
Sterile dressings, packs, etc.	85	14	2
Monitor FHR externally	44	33	23
Administer IV meds	72	26	2
Discharge planning	72	26	2
Nasogastric intubation	68	25	8

*All figures were rounded to the nearest whole number.

What can educators do about it?

As curriculum is examined, there are several adjustments that can be made, some of which do not require major curriculum revision. Educators in their planning should determine how best to incorporate the skills into the learning experiences, whether to approach the teaching from the practice laboratory, the clinical setting, or both. Effort should be made to designate a particular course as having responsibility for introducing the skill. If further proficiency is expected, then subsequent courses in the program of study should make appropriate plans. In this way, tracking proficiency is ensured. One school reported that they note such information on formal evaluation progress reports of students and expect these experiences as part of the successful achievement for the course. Practice with selected advanced procedures should not be left to chance any more than those in the more basic categories are left to chance.

Attention must be paid to the practice laboratory. There are a number of procedures that might be cited as examples when one is considering changes that are necessary. To dismantle the mystique and avoidance associated with revitalizing the practice laboratory, it is possible that educators themselves may need to become more familiar with equipment and the performance of certain procedures. They may also need to discard outdated equipment and teach with current technical devices.

Temperatures are no longer taken with mercury thermometers. We should be teaching temperature taking with digital thermometers. While

Table 3 *Skills with 100% of respondents stating the minimum needed is introductory knowledge*

Skill	RNs (%)		
	Can perform without supervision	Can perform with supervision	Should have knowledge of but does not need to perform
Assessment—total (head to toe)			
Heart sounds	81	14	6
Lung sounds	85	13	2
Abdomen	87	11	2
Neuro	80	18	2
Venipuncture, adult, and pediatric	62	36	2
Administering IV medications			
Piggyback	75	23	2
Direct	73	26	1
Heparin lock	73	26	1
Subclavian dressing change	61	25	4
Body substance Precautions/isolation	90	9	1
IV site care/changing tubing	86	14	1
Accuchecks (blood glucose levels)	74	21	5
Sterile suctioning/ Endotracheal/tracheal	65	34	1
Care of chest tubes/equipment	45	50	5
Hemovac/drains	71	27	2
Specimen collections (sputum, stool, smear)	89	11	—
Blood and blood products administration	55	43	2
Lavage/gavage	59	38	3
Wound irrigation	63	33	4
Sterile dressings, packs, etc.	78	20	2
Monitor FHR externally	44	33	23
Administer IV meds	70	28	2
Discharge planning	76	21	3
IV controllers	66	30	4
TPN	44	42	14

*All figures were rounded to the nearest whole number.

manual assessment of blood pressure is still common, it is nearly as common for students to encounter digital equipment for this technique in the clinical setting, and they need access to it in practice. If time is spent checking glucosuria with various tapes and sticks, this should be drastically minimized, as students can read instructions on the container. It is far better for them to be comfortable with the electronic equipment used for measuring blood glucose, since it is more complicated and used almost exclusively in hospitals for determining insulin dose.

Academic programs have notoriously suffered for lack of funds to keep laboratory settings properly equipped and maintained. If this poses a problem, arrangements with clinical agencies could be made to borrow equipment on a short-term basis or solicit use of their educational facilities for this purpose. It may be time for academe to ask manufacturers to supply models (perhaps modified for those that are expensive) that can be used for education and practice once they have sold a product to an agency that functions as a clinical teaching institution for nursing education.

Proficiency with the previously mentioned procedures should be expected early in the study of nursing. Introducing electronic equipment whenever possible in the practice laboratory helps students develop a more realistic sense of what is to come in the clinical setting. Not only does it facilitate adjustment from one environment to the next, it should also enhance ability to adapt to more advanced equipment and procedures when encountered. As students are learning in the clinical setting, assigning them to work one on one with a staff nurse helps them to gain skill and confidence with complex procedures.

Technical devices and complicated procedures will not dissipate; they will

Table 4 *Skills Taught by All of the Schools Surveyed*

Administration of IV piggyback medications
Interpretation of lab data: Blood gases
Interpretation of lab data: Blood chemistry
Interpretation of lab data: Urinalysis
Interpretation of lab data: Serology
Nasogastric intubation
Body substance precautions/ isolation procedures
IV site care/changing tubing
Specimen collections (sputum, stool, smear)
Sterile dressings, packs
Hemovacs/drains

Table 5 *Skills Not Taught by the Schools Surveyed*

Skill	Percent	Skill	Percent
PCA pumps	27	Monitoring ventilators	50
Monitoring CVP	30	Set up CVP monitoring	63
Use of special care beds	38	Monitoring hemodialysis	63
Monitoring intrauterine contaction pressure	40	Administering peritoneal dyalysate	64
Monitoring FHR internally	41	Life support/ defibrillation	65
Arterial lines-monitoring	42	Set up ventilators	87
Use of computers	43	Attaching internal fetal electrodes	87
Life support/medication administration	49	Set up hemodialysis	92
Chemotherapy/administration	49	Perform arterial puncture	93

only increase as scientific advances continue. Since there are fewer units within hospitals where new graduates can be assigned without encountering a number of advanced techniques, educators must focus their attention more acutely on reality. The reality is especially astounding when one contemplates the figures in Table 5 and realizes that a large number (ranging from 27% to 93%) of associate degree programs in this study do not in any way teach the techniques identified on this list. Yet, these very procedures compromise 18 out of the 54 items listed in Tables 2 and 3 and specified as important to nurses providing care in the full-service hospital.

Nursing service has made a tremendous contribution in providing preceptorships and orientation for neophytes. It seems that it is now time for educators to listen to the voice of our counterparts in nursing service and hear what they have to say concerning what new graduates need in order to function adequately as they enter the profession.

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Transformational Leadership

A Sense of Nursing History

Official Publication of the National League for Nursing

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Sister Rosemary Donley

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Transcultural Nursing AND Nursing Diagnoses

Elaine M. Geissler

During the course of a study to validate the use of selected nursing diagnoses with culturally diverse patients, many respondents wrote *unsolicited* comments on their questionnaires or in attached letters. The respondents were all members of the International Transcultural Nursing Society and/or the American Nurses' Association Council on Cultural Diversity in Nursing Practice. Two hundred and forty-five responses were received from 43 states and the District of Columbia, and 16 responses were received from 7 foreign countries: Canada, the Philippines, Sweden, Pakistan, Saudi Arabia, Israel, and Malawi. The desire of these registered nurses (RNs) to improve the status quo, as well as their frustration with the inadequacy of nursing diagnoses in their transcultural nursing practices, became evident. These opinions about the cultural limitations of the North American Nursing Diagnosis Association (NANDA) diagnoses are reported here.

In recent decades, nursing's movement to a more holistic perspective reflects an increased diversity of nursing practice and improved identification of patients' needs. Transcultural nursing recognizes that regardless of the medical diagnosis, it is important to plan nursing care around the unique cultural health care beliefs, values, and practices of patients.

The first organized attempt to develop a classification system for nursing concerns by NANDA was begun in 1973. To date, there has been minimal impact by the evolving transcultural nursing knowledge and practice base upon the content of nursing diagnoses. At best, the list of officially accepted nursing diagnoses (NANDA, 1989) contains only a few cultural defining characteristics and cultural factors that appear to be antecedent to or related to a given nursing diagnosis. Nurses expert in transcultural nursing need to help close this gap and lead the way for integration of culture care into nursing practice.

General comments

General comments about the use of nursing diagnoses to meet the needs of culturally diverse patients were split between those nurses who felt that the NANDA diagnostic classification data base is not adequate and found it impossible to complete the questionnaire, and those who desired to seek accommodation with the system. For example, comments included "I have decided after trying to think about and fill out the questionnaire that I cannot participate," and "Many TCN [transcultural nursing] individuals are so frustrated with NANDA's list that they want to 'throw out the baby' too. More explanation needs to be given on how to adapt the other NANDA diagnoses to be culturally congruent." A few nurses believed that the negatively worded language of nursing diagnoses did not reflect a positive transcultural nursing view. NANDA's most common problems were reported as:

1. Patient, rather than provider or system focused: NANDA diagnoses and behaviors assume the client is "wrong" and the provider is "right" denying the validity of cultural and health care beliefs and practices different from those of the nurse. Patient-focused diagnoses alone are inadequate because it is the nurse from the dominant culture within the health care agency who may be impaired and ineffective.
2. Generalizing: The NANDA system is difficult to generalize among cultures, and there is danger of stereotyping and victimizing. So-called deviations from the dominant culture are automatically and ethnocentrically considered abnormal, thus, interventions from nurses are needed. In reality, other traditional health/illness practices may be far different from the Western health care system model and normal in the patient's culture.
3. Mislabeling: Cultural dissonance as the base etiology of the patient's problem needs to be separated from political, social, psychological, and economic factors.

Respondents also expressed concern over the ability of the study to improve congruence between NANDA's listings and patients' culturally diverse needs. For example, "This is still an attempt by marginally linguistic phraseology to use psychological, social, and some physical terms related to culture. The cultural care is missing. We surely don't want this or we fail to meet TCN purposes." Another nurse wrote, "Trying to do this is a futile and offensive exercise." The respondent did not explain if she was responding to the questionnaire, nursing diagnoses, something else, or everything in general.

General comments were categorized into the following problem areas: (1) inadequacy of NANDA, (2) inadequacy of study, (3) patient-focused nursing diagnoses, (4) generalizing, and (5) mislabeling (Table 1). Four of the five problems were of equal concern (21.7%), with mislabeling of nursing diagnoses (13%) ranked second. All the unsolicited comments were handwritten by respondents and seemed to have emotional messages embedded within them. The way the responses were written, as well as the choice of

Elaine M. Geissler, PhD, RN, CTN, is an associate professor of nursing at the University of Connecticut, Storrs, Connecticut.

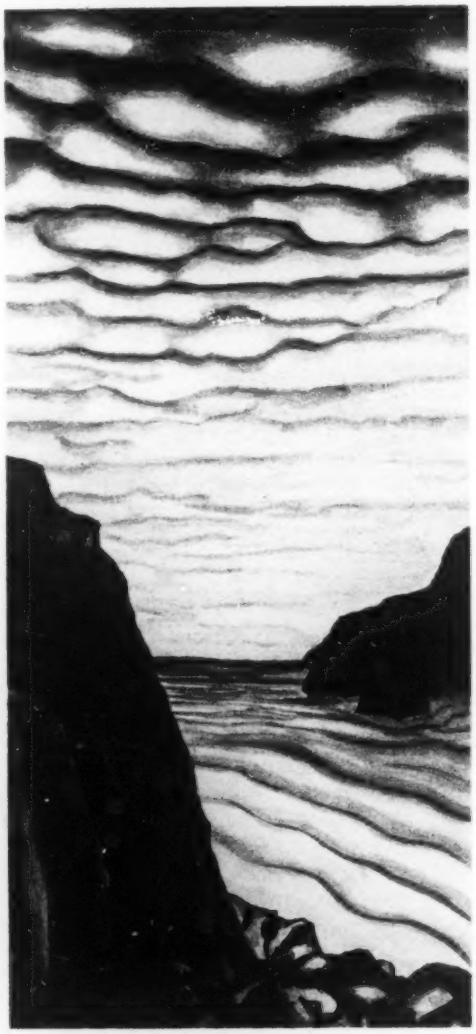
words, were analyzed.

The degree of discontent with the identified problems was extracted from the comments by creating three potential levels of discontent. This approach is suggested by Seymour (1990) with adaptations. Three points were assigned to words or phrases indicating relatively strong negative feelings. For example, "It disturbs one to see it [transcultural nursing in nursing diagnoses] incorporated so negatively." No expletives were found but would have been included in this level. Two points were assigned to exclamation points, highlighting certain words by underlining, and the use of cap letters. For example, "The major problem I have with most of this is that the diagnosis indicates a patient problem—when we the nurses may be the impaired or ineffective." One point was assigned to comments that expressed discontent but without any emphasis devices. For example, "These diagnoses do not consider lots of variables and could lead to labeling and stereotyping." The number of actual points divided by the total possible points resulted in the percent of discontent reported in Table 1.

The simple listing of the problems by frequency and percent revealed some information. But when the level of discontent is added, the data are much more informative. Discontent with the study itself and with the NANDA classification system ranked among the highest (53.3% and 50%, respectively), assuming that the patient is "wrong" and the provider is "right" (30%), and mislabeling nursing diagnoses as having a cultural etiology (27.8%) were of moderate concern. The danger of generalizing or stereotyping ranked the lowest (16.7%).

Verbal communication diagnosis

The first NANDA nursing diagnosis looked at was impaired verbal communication related to cultural differences. NANDA defines this diagnosis as "The state in which an individual experiences a decreased or absent ability to use or understand language in human interaction" (NANDA, 1989, p. 49). When this diagnosis is related to cultural differences, the respondents had considerable difficulty with the diagnosis, the way the related factors are stated, and the defining characteristics indicating presence of the diagnosis. Certainly, inability to use the dominant language of the health care system providers and/or cultural differences in verbal and nonverbal expressions between the patient and the provider must be taken into account. Neither the nurse nor the patient has impaired verbal communication skills when both are adequately fluent in their own languages. The problem is one of barriers to mutual understanding, not the ability to communicate verbally. The nurse



Geissler looks at the fit of nursing diagnosis and transcultural nursing, and she finds nursing diagnosis—at least the most popular taxonomies—wanting. Are our formulations or nursing diagnosis culture-bound?

Key words: transcultural nursing, nursing diagnosis, NANDA, labeling, communication

bears equal responsibility for being *impaired*, if that term is applied.

Defining characteristics addressing pathophysiological causes of the inability to speak, for example, aphasia and stuttering, are irrelevant within the context of cultural-language variance. One nurse suggested adding "...not secondary to physical or psychological disorders" to the end of NANDA's definition. The NANDA classification appears to be used with the assumption that the dominant language is English when it would be more explicit and internationally serviceable to state the defining characteristic as being unable to speak the dominant language of the health care system.

Cultural expression includes nonverbal communication and is different from understanding verbal language. NANDA's descriptors are exclusively directed toward verbal communication and inappropriately relate them to cultural differences, yet the nonverbal expressions of every culture are critical to mutual understanding and may have nothing to do with knowledge of the dominant language.

"Some groups do not value verbalization as much as the dominant culture, however, this isn't a diagnosis; its a norm for that group," one nurse reminds us. With culturally diverse English-speaking clients, mutual understanding may be assumed, but false. For example, when the word *house* is used by a patient, the mental image visualized by the nurse is most likely a middle-class bias of what a house looks like, regardless of whether the two are communicating in English or in the patient's own language.

Culturally based stress and conflict may have no relationship to knowledge of the dominant language, or it may be related to the very real stress of attempting to express oneself in the "foreign" language. Differentiation between these two etiologies is essential for accurate diagnosis and intervention.

. . . It is important to plan nursing care around the unique cultural health care beliefs, values, and practices of patients.

Table 1
Frequency of Problems and Expressions of Discontent

Problem	*f*	%	Discontent (%)
Inadequacy of NANDA	5	21.7	50.0
Inadequacy of study	5	21.7	53.3
Patient focused	5	21.7	30.0
Generalizing	5	21.7	16.7
Mislabeling	3	13.0	27.8
TOTAL		99.9%	

Social interaction diagnosis

The second NANDA nursing diagnosis considered was impaired social interaction related to sociocultural dissonance. The most frequently repeated theme of comments concerned who sets the parameters for what is and is not sociocultural dissonance and who determines dysfunctional behaviors. A more appropriate nursing diagnosis offered was "decreased social interaction." Interaction difficulties must be specified as with the dominant culture, the patient's own culture, or both. One respondent reminds us, "Dysfunction is relative and culturally defined," while another states, "It disturbs me that no attempt is made...to distinguish behavior within our cultural group from behavior in providers' culture."[5] Dissonance only makes sense within a cultural context of health care beliefs, values, and practices.

NANDA defines impaired social interaction as "The state in which an individual participates in an insufficient or excessive quantity or ineffective quality of social exchange" (1989, p. 50). What is excessive quantity is questioned as is the lack of any defining characteristic to identify it. The reason for the patient's involuntary dislocation or voluntary relocation from their original cultural group must be identified to differentiate between political refugees and immigrants or migrants with or without immediate access to family and cultural support systems. Interviewing a patient may seem innocuous to the nurse but may be perceived as a threatening interrogation by a political refugee who is unaccustomed to the exchange of large amounts of personal information in our health care system.

Respondents also viewed the related factor of sociocultural dissonance as vague; a psychological, not a cultural, assessment; and more suggestive of cognitive dissonance. The etiological basis for, accurate definition of, and identification of signs of cultural dissonance are imprecise and difficult to apply in this nursing diagnosis when one is treating patients with cultural variance.

Noncompliance diagnosis

The third and final NANDA nursing diagnosis explored was noncompliance related to patient value system: health beliefs and cultural influences. This nursing diagnosis generated the largest and most emotional number of unsolicited comments and an attached letter. Considerable debate occurred over the phrase *informed decision* in the following NANDA definition for noncompliance: "A person's informed decision not to adhere to a therapeutic recommendation" (1989, p. 67). The consensus was that when a patient decides not to comply for religious, cultural, or other reasons, ethically the nurse should not attempt to alter the behavior. Because the patient often does not share the nurse's view of the cause of health problems, judgment about noncompliance becomes a manifestation of the nurse's own culture and ethnocentric view of health care, and a value conflict ensues. The provider assumes her or his opinion is superior. No matter which value system is followed, the patient's or the provider's, an *informed* decision becomes the patient's *right* to choose.

"According to most published definitions of noncompliance, it is required that the client express desire to comply but inability to stick to

CONTINUED

recommendations," writes one respondent arguing why no diagnosis should be made at all. Another nurse simply wrote, "I hate this!" Others disagree with the diagnosis when it is used in transcultural care settings.

The potential relationship between noncompliance and a person's concept of time was mentioned twice. It has been documented that different cultures view time with varying degrees of importance. "This diagnosis represents imposition of an unacceptable and/or unfamiliar set of expectations on the patient and then proceeds to blame the victim for failure to comply," explains one nurse who will not use this diagnosis in her practice while it remains worded as it is. "Frankly, it embarrasses me!" she writes.

A more culturally relevant diagnosis would employ the word *nonadherence* rather than noncompliance. Nonadherence is a less value laden term that might result in a different set of defining characteristics for this diagnosis. Other nurses believe that noncompliance is often related to a failure in communication or to the patient's belief that treatment would harm him, or it is the provider's assumption that negative consequences would occur from failing to follow the dominant medical/health regimen. One interesting comment suggested that noncompliance is very common in *all* groups regardless of social class or culture and may be related to a personality trait such as compulsiveness, which occurs on an individual level. The comments offered the strong opinion that noncompliance is ethnocentric—a slanted view of the situation reflecting a lack of understanding of the nature of noncompliance related to patients' beliefs, values, and health care practices.

Conclusion

Registered nurses expert in transcultural nursing knowledge and practice have offered their unsolicited opinions that these three nursing diagnoses officially sanctioned by NANDA for use in nursing practice are not adequate to meet the needs of culturally diverse patients. NANDA's most common problems were categorized as (1) assuming the patient is "wrong" and the provider is "right," (2) generalizing or stereotyping behaviors, and (3) mislabeling the etiological basis of a patient's problem as cultural without recognizing other potentially more relevant variables. There was sincere concern expressed that the study would not help ameliorate the status quo.

Neither the nurse nor the patient has impaired verbal communication skills when both are adequately fluent in their own languages.

Responses about the NANDA classification system's use in cultural diversity suggested a dichotomy between not using the system at all and accommodating the system for use in culture care. The reason more commonly given for not using the classification system was because it does not demonstrate respect of patients' individual health care beliefs, values, and practices. Another part of this study looks into the specific changes needed to make the defining characteristics for each of these nursing diagnoses more congruent with transcultural nursing.

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